Triennial Report

Queensland Maternal and Perinatal Quality Council

2022, 2023 and 2024

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Advice Summary

This triennial report (2022–2024) presents the key activities, report findings, recommendations, and outcomes of the Queensland Maternal and Perinatal Quality Council (QMPQC), referred herein as the Council, and its subcommittees. It highlights the Council's efforts to improve maternal and perinatal health outcomes across Queensland through data-driven insights, stakeholder engagement, quality improvement initiatives and education.

Introduction

The Council serves as the peak body within Queensland Health, dedicated to monitoring and enhancing maternal and perinatal outcomes throughout the state. The work of the Council is supported by its three sub-committees - the Maternal Mortality Sub-Committee, the Perinatal Mortality Sub-Committee, and the Congenital Anomalies Sub-Committee.
The Council collates data and performs comprehensive reviews of patient records examining health care related to maternal or perinatal deaths, to identify any contributing factors, and develop recommendations to prevent such clinical incidents occurring.
The Council's core objectives are:

- collect and analyse clinical information to assess, evaluate and report on Queensland's maternal and perinatal mortality and morbidity, and the safety and quality of maternity services in Queensland.
- make recommendations to the Deputy Director- General Clinical Excellence Queensland on standards and quality indicators of maternal and perinatal clinical care, to enable health providers in Queensland to improve safety and quality, and to monitor the implementation of those recommendations.
- provide advice to the Queensland Minister for Health, Mental Health and Ambulance Services and Minister for Women (Health Minister) and the Queensland Department of Health (DoH) on maternity concerns including obstetric and perinatal matters occurring in Queensland.

Functions

With respect to maternal and perinatal mortality and morbidity in Queensland, the Council will:

1. **Data Collection and Analysis**
   Collect, analyse and evaluate clinical information to report on maternal and perinatal mortality and morbidity, and to assess the safety and quality of maternity services provided in Queensland.
2. **Surveillance and Monitoring**
   Investigate and monitor state-wide and facility-specific themes and trends related to the incidence and causes of maternal and perinatal mortality and morbidity, to identify issues requiring action or further investigation.
3. **Ministerial Reporting**
   Report significant issues and concerns directly to the Minister for Health in a timely manner.
4. **Clinical Standards and Recommendations**
   Provide evidence-based recommendations to the Deputy Director-General, Clinical Excellence Queensland (CEQ), and the Director-General, Queensland Health, regarding standards and quality indicators for maternal and perinatal care. The Council will also monitor the implementation of these recommendations by health service providers.
5. **Collaboration and Advice**
   Collaborate with relevant national and state entities to develop, monitor and provide advice on guidelines, standards and quality improvement activities for maternal and perinatal services. Key partners may include:
   - Australian and New Zealand Neonatal Network (ANZNN)
   - Australian Institute of Health and Welfare (AIHW)
   - Clinical Excellence Queensland (CEQ)

- Communicable Diseases Branch (CDB)
- Hospital and Health Services (HHSs)
- Office of the Health Ombudsman (OHO)
- Office of the State Coroner
- Patient Safety and Quality (PSQ)
- Perinatal Society of Australia and New Zealand (PSANZ)
- Queensland Centre for Perinatal and Infant Mental Health (QCPIMH)
- Queensland Maternity and Neonatal Clinical Network (QMNCN)
- Queensland Paediatric Quality Council (QPQC)
- Queensland Public Health and Scientific Services (QPHaSS)
- Queensland Rural and Remote Clinical Network (QRRCN)
- Queensland Sexual Health Clinical Network (QSHCN)
- Retrieval Services Queensland (RSQ)
- Statistical Services Branch (SSB)
- Stillbirth Centre of Research Excellence

6. **Dissemination of Findings and Recommendations**
   Promote quality and safety improvements in maternity and neonatal care through:
   - Reporting on maternal and perinatal mortality and morbidity
   - Issuing recommendations to public and private health services
   - Monitoring the uptake and implementation of these recommendations
   - Publishing findings in accessible formats to guide system-wide learning and reform
7. **Education and Capacity Building**
   Provide education and guidance to Hospital and Health Services and private hospital providers on changes to care practices based on QMPQC recommendations and identified good practice points.
8. **Information Sharing to Support Council Functions**
   Engage in collaborative work through the provision of relevant clinical information and analysis, including:
   - Qualitative and quantitative data from public and private health facilities, and other regulatory bodies (e.g. SSB, OHO, PSQ)
   - Coronial documents such as autopsy and toxicology reports, coronial findings, and Form 1 Police Reports
   - Insights from literature reviews, expert knowledge, and other appropriate sources

The Council Activities and Outcomes for 2022

Report of the Queensland Maternal and Perinatal Quality Council 2021: Queensland Mothers and Babies 2018–2019

In 2022, the Council published the *Report of the Queensland Maternal and Perinatal Quality Council 2021:Queensland Mothers and Babies 2018–2019*

Report Summary:

- This Report focuses primarily on the 119,203 mothers who gave birth to 120,946 babies in Queensland in 2018 and 2019. This includes the 8,618 (7.2 percent) women who identified as Aboriginal and/or Torres Strait Islander and their 8,754 babies.
- The Report makes **26 recommendations** regarding maternity and newborn care and sets out 32 good practice points, which are of importance to all clinicians working in maternity and newborn services across Queensland.

Highlights of the report include:

- Higher rates of antenatal care during the first trimester were found among women who gave birth in private facilities (93.7 percent) compared to women who gave birth at home (69.1 percent) or in public facilities (74.1 percent). During 2018 and 2019, 96 per cent of pregnant women received more than the recommended number of five antenatal visits, with attendance of Indigenous women attending the recommended number of antenatal visits, also increasing from 78.8 per cent in 2010 to 90.8 per cent in 2019.
- Smoking at any time during pregnancy was more common among women in Queensland than nationally (11.4 percent vs 9.9 percent), particularly during the first 20 weeks of pregnancy (11.4 percent vs 9.1 percent). 18.1 percent of women who smoked in the first 20 weeks did not continue to smoke after 20 weeks gestation. 23.3 percent of younger women (those aged under 20 years) smoked after 20 weeks gestation compared to 9.5 percent of women aged 20-34 and 6.7 percent of women aged 35 and older. Of Aboriginal and Torres Strait Islander women, 37.5 percent smoked after 20 weeks gestation (down from 46.7 percent in 2010).
- Congenital Heart Disease (CHD) cases in Queensland account for more perinatal deaths than any other congenital anomaly: between four and ten per 1,000 livebirths. Pulse oximetry screening (POS) reduces both morbidity and mortality in infants with undetected critical congenital heart disease (cCHD).
- In Queensland congenital syphilis notifications have had a significant increase, from 3.1 to 22.9 cases per 100,000 population/year between 2001 and 2019. There were 23 cases of congenital syphilis reported from 2011 to 2019 which resulted in intrauterine death or stillbirth, all of whom were born to First Nations women.
- The Maternal Mortality Ratio (MMR) 2018 and 2019 is 5.0 per 100,000 births, which is slightly lower than the national figure of 5.7 per 100,000 births. 36 maternal deaths occurred either during pregnancy or up to one year after the end of pregnancy in 2018 and 2019. 12 of 36 maternal deaths in Queensland occurred by suicide, which continues to be a public health issue of concern. Six women died from cardiac conditions and four from malignancies.
- The perinatal mortality rate of 9.8 per 1,000 births (stillbirth rate 6.8 per 1,000 births, and neonatal mortality rate 3.0 per 1,000 live births), is slightly higher than the national perinatal mortality rate for the same period, 9.5 per 1,000 births (stillbirth rate 7.1 per 1,000 births, and neonatal mortality rate 2.4 per 1,000 live births). The neonatal mortality rate of 3.0 per 1,000 live births in Queensland is higher than the national rate of 2.2 per 1,000 live births, with the stillborn rate 6.8 per 1,000 live births being lower than the national rate of 7.1 per 1,000 live births. Babies born to Aboriginal and Torres Strait Islander women have higher rates of perinatal deaths. Stillbirths and neonatal deaths occur in Aboriginal and Torres Strait Islander women at 1.6 and 1.8 times the rate of babies born to non-Aboriginal and Torres Strait Islander women, respectively.

- There is a significant disparity in neonatal deaths between babies born at term, to Aboriginal and Torres Strait Islander women and babies born to non-Aboriginal and Torres Strait Islander women, which can be attributed to higher rates of maternal diabetes, perinatal infection, fetal growth restriction and unexplained antepartum fetal death in Aboriginal and Torres Strait Islander women.
- In 2019, spontaneous preterm birth (30.8 percent) and congenital anomaly (30.3 percent) were the leading causes of neonatal deaths. Contributing factors were identified in 53 (62.3 percent) of the perinatal deaths reviewed. In 18 cases (34 percent) with contributing factors, it was considered that sub-optimal care had significantly contributed to the outcome.
- The purpose of an autopsy is to accurately identify the cause(s) of death, however in Queensland perinatal autopsy rates remain low, with 22.9 percent of neonatal and 38.3 percent of stillbirth deaths having an autopsy examination in 2018 and 2019. This compares to a national autopsy rate of 41.3 percent for neonates and 26.7 percent for stillbirths in 2019.

Mothers and pregnancy

The proportion of women giving birth at 35 years of age and over increased slightly between 2010 and 2019, while the proportion of mothers aged under 20 decreased. Birthing women of Aboriginal and Torres Strait Islander origin were approximately five times more likely to be aged under 20 than women of non-Aboriginal and Torres Strait Islander origin. Multiple pregnancies represented 1.4 percent of all pregnancies with almost all (98.4 percent) being twins. One in five (19.5 percent) multiple pregnancies occurred where assisted conception techniques had been used. Higher rates of antenatal care during the first trimester were found among women who gave birth in private facilities (93.7 percent) than among women who gave birth in public facilities (74.1 percent) or at home (69.1 percent). Smoking during pregnancy was more common among women in Queensland than nationally (11.4 percent vs 9.9 percent), particularly during the first 20 weeks of pregnancy (11.4 percent vs 9.1 percent). Women who stop smoking during pregnancy can reduce the risk of adverse outcomes, and 18.1 percent of women who smoked in the first 20 weeks did not continue to smoke after 20 weeks gestation. The proportion of women giving birth in private hospitals has not changed substantially over the last decade, with 76.2 percent of women giving birth in a public hospital and 22.8 percent giving birth in a private hospital. The overall rate of births with no labour in private facilities is much higher than the rate in public facilities 41.2 percent and 17.5 percent, respectively). Babies and birth. Gestational age is an important determinant of perinatal outcome with 9.2 percent of babies born preterm (before 37 weeks) and 0.3 percent born post-term (42 weeks and over). There has been little change in these proportions over the past decade. There has not been a significant change in the percentage of babies born with low birthweight (less than 2500g) over the past 10 years (6.4 percent in 2010 and 2011; 6.8 percent in 2018 and 2019). Babies born small for gestational age (SGA) are more prevalent for Aboriginal and Torres Strait Islander mothers 13.1 percent compared to 8.3 percent of SGA babies born to non-Aboriginal and Torres Strait Islander mothers.

The percentage of liveborn babies admitted to a special care or intensive care nursery was 26.9 percent, which is higher than the national average in 2019, of 18 percent, although these figures are not strictly comparable. This is often due to being born preterm or due to a congenital anomaly (and sometimes both).

Congenital anomalies

Congenital anomalies are the leading cause of perinatal deaths in Australia. Queensland has had a significant increase in congenital hypothyroidism and ventricular septal cardiac defects over the past 12 years. These congenital anomalies are both associated with pre-existing diabetes. Congenital Heart Defects (CHD) remain one of the leading causes of perinatal deaths in Queensland. Pulse oximetry screening (POS) performed during the birth admission has been implemented in only half of all Queensland birth hospitals. Routine POS for all births has been established on high level evidence to increase detection of CHD during the birth episode allowing earlier intervention and a reduced mortality and morbidity in critical CHD infants.

Congenital syphilis

In 2017, infectious syphilis and the re-emergence of congenital syphilis affecting babies in Queensland was identified as an important issue by the Council. Consequently, a Congenital Syphilis Working Group (CSWG) was convened from 2018, tasked with the review of all Queensland cases of congenital syphilis that occurred between January 2010 and January 2022 (27 cases) and included 9 deaths.

There has been an infectious syphilis outbreak affecting young Aboriginal and Torres Strait Islander people in North Queensland since 2011. The South-East corner of Queensland has also experienced rapid increases of infectious syphilis in women of reproductive age (15–44 years) since 2016. This is concerning because of the increased risk of syphilis in pregnancy and congenital syphilis. In 2019, 66 percent of Queensland infectious syphilis notifications were from the highly populated South-East Queensland (SEQ) region. In that same year, the highest notification rates of infectious syphilis were reported in Aboriginal and Torres Strait Islander women. The prevention of vertical transmission during pregnancy is key to avoiding poor outcomes for mothers and their babies.

Maternal mortality

There were 36 maternal deaths either during pregnancy or up to one year after the end of pregnancy. Seven of these deaths occurred in pregnancy or during the first six weeks postpartum. These were classified as direct or indirect, thereby contributing to a Maternal Mortality Ratio (MMR) for 2018 to 2019 of 5.0 per 100,000 births, which is slightly lower than the national figure of 5.7 per 100,000 births. Most prominently, 12 deaths in Queensland occurred by suicide, which continues to be a public health issue of concern that requires urgent attention. Six women died from cardiac conditions and four from malignancies. Attention is drawn to the importance of mental health follow-up. Screening in the antenatal and postnatal period has been instituted in Queensland for several years. Still in many parts of Queensland there have not been resources dedicated for referral pathways and perinatal mental health services. There are also insufficient resources to care for women who are identified through screening processes, diagnosed with or at high risk of perinatal mental health concerns. The continuing lack of dedicated public mother-baby beds for women with significant perinatal mental health diagnoses is a major concern. ***Suicide*** is the leading cause of maternal death, and little is known about the circumstances in which these deaths occur.

Perinatal mortality

There were 1187 perinatal deaths, giving a perinatal mortality rate of 9.8 per 1000 births (stillbirth rate 6.8 per 1000 births, and neonatal mortality rate 3.0 per 1000 live births). The national perinatal mortality rate for the same period was 9.3 per 1000 births (stillbirth rate 7.1 per 1000 births, and neonatal mortality rate 2.2 per 1000 live births). The rate of stillbirths has not changed significantly over the decade 2010 to 2019 (annual percentage change: 0.3; 95 percent CI: -0.8, 1.3) while the neonatal death rate has declined modestly (annual percentage change: -1.8; 95 percent CI: -3.3, -0.2). Babies born to Aboriginal and Torres Strait Islander women have higher rates of perinatal deaths. Stillbirths and neonatal deaths occur at 1.6 and 1.8 times the rate of babies born to non-Aboriginal and Torres Strait Islander women, respectively.

The leading cause of stillbirth was congenital anomaly, accounting for 38.3 percent of all stillbirths in 2018 and 32.6 percent in 2019. Almost one quarter (23.4 percent) of stillbirths in 2018 and 14.5 percent in 2019 were classified as unexplained. At term, those proportions increased to 44.4 percent in 2018 and 33.3 percent in 2019. Note: These percentages are based on Perinatal Society of Australia and New Zealand (PSANZ) classification. The classification of 2018 and 2019 cannot be compared due to different PSANZ classification codes.

The percentage of autopsies undertaken remains low, with 38.3 percent of stillbirth and 22.7 percent of neonatal deaths having an autopsy examination in Queensland. While most stillbirths are due to antepartum fetal death, attention to intrapartum deaths is important due to the potential for prevention, particularly at late gestations. In 2018, the leading cause of neonatal deaths was spontaneous preterm birth with related complications accounting for 41.6 percent of all neonatal deaths; in 2019, spontaneous preterm birth (30.8 percent) and congenital anomaly (30.3 percent) were the leading causes of neonatal deaths.

The Perinatal Mortality Sub-Committee undertook a review of selected perinatal deaths that occurred in the 12-month period from 1 January to 31 December 2019. The aim of the review was to classify the reported deaths to identify potentially modifiable factors that might improve care. This included organisational and/or management factors, personnel factors and barriers for women accessing care. Eighty-five of the perinatal deaths in 2019 occurred between 34 weeks gestation and 28 days postnatal age and met criteria for review. This included 66 (78 percent) stillbirths and 19 (22 percent) neonatal deaths. The review panel found that in more than half of the cases reviewed, there were critical gaps in care. Contributing factors were identified in 53 (62.3 percent) of the perinatal deaths reviewed, comprising of 38 stillbirths (57.6 percent) and 15 (78.9 percent) neonatal deaths. In 18 of the 53 cases (34 percent) with contributing factors, it was considered that sub-optimal care had significantly contributed to the outcome. Whilst this represents a decrease of nine percent in suboptimal care factors

from the previous 2019 report, the results of the reviews echo previous critical gaps in care and missed opportunities. The findings from this body of work will also enable Queensland to meet its national reporting requirements with contributory factor data from in-depth clinical case reviews provided to the Australian Institute of Health and Welfare (AIHW).

Recommendations:

1. That Queensland Health develops strategies to improve access to culturally safe antenatal care, to increase early engagement and frequency of attendance by Aboriginal and Torres Strait Islander women.

2. That attention be given to increasing the rate of first antenatal visit prior to 14 weeks gestation, to allow for early intervention that might reduce a variety of adverse maternal and perinatal outcomes.

3. That all newborn infants in Queensland receive mandatory Pulse Oximetry Screening at their birth admission. Current findings in Queensland and internationally strongly support that universal Pulse Oximetry Screening reduces both morbidity and mortality in infants with undetected critical congenital heart disease.

4. That consideration be given to the diagnosis of congenital syphilis in any critically unwell infant; symptoms may include non-specific signs such as anaemia, thrombocytopaenia, hepatosplenomegaly, fever and rash.

5. That complete parallel testing of infant and mother be performed in all infants at risk of congenital syphilis, including rapid plasma reagin (RPR), infant syphilis antibodies (EIA IgM) and placental syphilis polymerase chain reaction (PCR).

6. That follow-up serology be conducted at 3, 6 and 12 months of age or until RPR is nonreactive to ensure treatment is effective.

7. That treatment of congenital syphilis be 10 days of intravenous benzylpenicillin.

8. That reducing congenital syphilis in Queensland requires RPR testing of pregnant women, of up to 5 times throughout pregnancy, if considered to be at elevated risk, with monitoring of pregnant women after syphilis treatment for reinfection, and inclusion of partner screening/ treatment and documentation.

9. That the development of a Queensland clinical guideline on perinatal mental health be prioritised.

10. That an urgent review be undertaken of perinatal mental health services, to ensure adequate resourcing and access, to identify current gaps.

11. That education around suicide safety planning and accessing acute mental health care be available to all health professionals and agencies who see women in the peripartum.

12. That comprehensive Perinatal Mental Health services across the continuum of ambulatory care, consultation, liaison and inpatient beds should be implemented state-wide.

13. That all Maternity Care Providers receive education about Complex Trauma, and the principles of trauma informed care.

14. That a dedicated mothers page be added to the Personal Health Record Child Health Information (PHR CHI) booklets documenting conditions or diseases incurred during pregnancy, highlighting the need for monitoring and follow-up alongside neonatal monitoring.

15. That all women should leave hospital with an agreed postnatal care plan which includes details of the practitioner, medical practice or community centre providing follow up care, significant issues requiring follow up, and a contraceptive plan.

16. That women should be provided with information on what to expect in the first 6 weeks postpartum in addition to the Baby's Personal Health Record (red book) and Child Health Information Guide to the first 12 months.

17. That maternity units delivering more than three thousand babies a year should have an obstetric medicine service on site.

18. That hospitals providing care with less than 3000 births per year should have strong links with an obstetric medicine department at their referring hospital.

19. In sites using electronic medical records, an electronic solution needs to be developed that allows for timely data sharing between hospital providers, GPs, midwives and women.

20. That an autopsy, and where appropriate and available, molecular investigations, be performed in all cases of maternal mortality. Consideration should be given to amending the Queensland Coroners Act 2003 to include investigation of all maternal deaths (including late deaths), except where there is a clear and unequivocally diagnosed cause of death, for example, a known metastatic malignancy.

21. That a systematic approach to reporting and reducing workplace intimidation, bullying, harassment and poor culture be developed for state-wide implementation within all Queensland hospitals.

22. That Queensland Health considers designating appropriately resourced tertiary perinatal pathology centres, for the performing of perinatal and neonatal autopsy investigation by perinatal pathologists. This, together with appropriate staffing, to ensure timely high-quality investigation of stillbirths and neonatal deaths, is vital.

23. That all maternity hospitals have effective processes (e.g. via Perinatal and Maternal Mortality Review Committees (PMMRCs) in place to ensure all perinatal deaths are appropriately investigated and classified according to the PSANZ national guidelines, for cause of death and contributing factors relating to care.

24. That all larger maternity facilities should have credentialled educators to deliver IMPROVE (Improving Perinatal Review and Outcomes via Education) workshops to help increase the uptake of perinatal autopsies and investigations in Queensland.

25. All maternity services should standardise their perinatal mortality reviews and incorporate the APMCAT into their local perinatal mortality reviews. The resulting underlying causes of stillbirths should be classified using the PSANZ perinatal mortality classification system and include an assessment of suboptimal care factors.

26. Consideration to be given to establishing a permanent part-time (0.4FTE) clinical midwife resource to provide discipline specific input across all areas of review by the QMPQC.

Report Outcomes:

A multi-layered statewide action plan was developed with key stakeholders who have worked in consultation to progress important improvement strategies against all recommendations. Improvement approaches are highlighted below:

Rec 3: *That all newborn infants in Queensland receive mandatory Pulse Oximetry Screening at their birth admission. Current findings in Queensland and internationally strongly support that universal Pulse Oximetry Screening reduces both morbidity and mortality in infants with undetected critical congenital heart disease.*

The Council wrote to the Acting Deputy Director General of Healthcare Purchasing and System Performance Division requesting the inclusion of mandatory pulse oximetry screening for all Queensland newborns at their birth admission on discharge, or as routine screening by community midwives if discharge was prior to 24 hours.

This request was agreed to and as such was included as a population health screening service in the Hospital and Health Service agreements, amended in October 2023 and published early 2024.

This screening is incorporated into the Queensland Clinical Guidelines: Newborn baby assessment (routine) and captured in Perinatal Data Collection as well as recorded in the Child Health Record.

Rec 9: *Develop a Queensland clinical guideline on perinatal mental health.*

Following the recommendation made in the QMPQC Report 2021 , that Queensland Health develop a perinatal mental health guideline, in April 2024, Queensland Clinical Guidelines published the first Perinatal mental health guideline.

Rec 26: *Consideration to be given to establishing a permanent part-time (0.4FTE) clinical midwife resource to provide discipline specific input across all areas of review by the QMPQC.*

In July 2024, CEQ allocated funding to support a permanent clinical midwife consultant within Patient Safety and Quality. This role provides clinical insights into maternity care, through clinical review and investigation of all facets of care related to maternity services, including the review and thematic analysis of relevant maternal and perinatal Severity Assessment Code (SAC) SAC1 analysis reports.

This role was instrumental in producing a ministerial report into stillbirths for 2022: Review of selected 2022 Perinatal Deaths Report

Educational Webinars

A series of educational Webinar pieces were conducted to disseminate findings of the Queensland Maternal and Perinatal Quality Council Report 2021: Mothers and Babies 2018–2019.

These sessions highlighted the 26 recommendations made and provided areas for improvement with good practice points targeted to all clinicians working within Maternity across Queensland.

The Webinars has been edited to create short, 10-15 minute snapshot educations session for clinicians and maternity care workers available on QHEPS.

The below links will only work for those with access to Queensland Health intranet.

Maternal Mortality Education Session | Friday 21 October 2022

QMPQC | Queensland Health Intranet: Education*

Presenter	Title of Presentation
Prof Ted Weaver Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service; Clinical sub-Dean, Griffith University School of Medicine	Welcome an overview of QMPQC
Dr Nikki Whelan Consultant Obstetrician and Gynaecologist	Maternal Mortality - Introduction to 2021 Report Findings

Presenter	Title of Presentation
Professor William Parsonage Staff Specialist, Cardiology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Complex cardiac conditions in pregnancy
Dr Meg Cairns General Practitioner/GP Liaison Officer, Metro North Hospital and Health Service and Brisbane North Primary Health Network	Shared Antenatal Care
Marcia Morris Assistant Nursing and Midwifery Director, ieMR implementation Lead – Maternity RBWH Metro North	Red flags – Importance of clinical assessments and when to escalate
Prof Ted Weaver Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service; Clinical sub-Dean, Griffith University School of Medicine	Condition and postnatal plan at discharge - Multidisciplinary care and services
Prof Leonie Callaway Director of Research, Women's and Newborn Services; Royal Brisbane and Women's Hospital and Executive Director of the Women's and Children's Stream, Metro North Hospital and Health Service	Trauma informed care
Dr Susan Roberts Clinical Lead, Lavender Mother and Baby Unit, Perinatal Psychiatrist, Gold Coast University Hospital, Gold Coast Hospital and Health Service	Perinatal mental health and Maternal suicide

Perinatal Mortality Education Session | Friday 4 November 2022

QMPQC | Queensland Health Intranet: Education*

Presenter	Title of presentation
Prof Ted Weaver Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service; Clinical sub-Dean, Griffith University School of Medicine	Welcome an overview of QMPQC
Dr Johanna Laporte Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital	Perinatal Mortality - Introduction to 2021 Reporting Findings
Imogen Kettle Clinical Midwife Consultant, QMPQC	Perinatal mortality contributing factors project
Dr Johanna Laporte Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital	Perinatal mortality audit/investigations
Professor Vicki Flenady Director, Centre of Research Excellence in Stillbirth, Mater Research Institute – The University of Queensland	National Stillbirth Action Plan
Tionie Newth Research Midwife, NHMRC Centre of Research Excellence in Stillbirth (Stillbirth CRE), Mater Health Services	Fetal growth assessment, Queensland IMPROVE
Adam Burns Principal Project Officer, Clinical Excellence Queensland	Queensland Safer Baby Bundle update
Dr Christoph Lehner Consultant Obstetrician, Fellow in Maternal Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Australian Pre-term Birth Prevention Alliance

*Above links will only work for those with access to Queensland health intranet.

Perinatal Mortality Contributing Factors Case Review:

The Council performed a second perinatal confidential enquiry carried out as part of the Perinatal Mortality Contributing Factors Cases Review Panel body of work. The panel undertook a review of selected perinatal deaths occurring after 34 weeks' gestation to identify contributing factors relating to care (substandard care factors). The review of perinatal deaths is the key to improving perinatal outcomes by:

1. identifying potentially avoidable deaths and
2. using the examination of clinical circumstances surrounding these deaths, to improve the safety and quality in healthcare systems. The aim of the review process was to systematically identify and classify modifiable components of the health care system. This includes a broad spectrum of organisational and/or management factors, personnel factors and barriers for women accessing care.

In 62 percent of the reviewed perinatal deaths, substandard care factors were identified that were either significantly, possibly, or insignificantly attributed to the outcome. Whilst this represents a decrease of nine percent in substandard care factors from the previous 2019 report, the results of the reviews echo previous critical gaps in care and missed opportunities. Queensland Mothers and Babies, 2018–2019: Report of the Queensland Maternal and Perinatal Quality Council 2021.

Following the review of these cases it was identified that the use of home fetal heart monitors (dopplers) by parents had been a contributing factor to a perinatal death. Between 2021-2022, the QMPQC through the PMSC, identified four clinical incidents related to the use of home fetal dopplers. The four clinical incidents were of mothers, concerned by a lack of fetal movement, being falsely reassured with the use of a home fetal dopplers which caused a delay in presenting to a maternity facility for review. This delay in presentation for assessment, may have been a contributing factor to three babies being stillborn and one dying shortly after birth.

This resulted in a joint publication by the Council and Patient Safety and Quality, CEQ, a Patient Safety Communiqué and a patient information factsheet. This patient focused factsheet was disseminated to GPs, private obstetricians and displayed in all public hospital and health services, maternity patient areas.

Contributing Factors Case Review Outcomes:

The Council in conjunction with Clinical Excellence Queensland, Queensland Health, raised concerns about the use of home fetal heart monitors (dopplers) with the Therapeutic Goods Administration (TGA) because of the findings from the QMPQC's Perinatal Mortality Contributing Factors Cases Review Panel.

The TGA undertook a post-market review of all home use dopplers included in the Australian Register of Therapeutic Goods (ARTG). The purpose was to determine whether the risk of using these devices outweighed the potential benefit.

- ✓ On September 4, 2024, the TGA published the findings of their review. They announced: "All home-use fetal dopplers that were intended to be used without the supervision of a healthcare professional have been removed from the ARTG." The cancellation means home-use devices will no longer be available for purchase.
- ✓ The TGA also considers Baby Movement Apps to be medical devices and must be included in the ARTG. These digital products may deter people from seeking medical attention if they are concerned about their baby's well-being.

Australian Government Therapeutic Goods Association (2024) Post-market review of home-use fetal dopplers

QMPQC Activities and Outcomes for 2023

Queensland Maternal and Perinatal Quality Council Congenital Syphilis Working Group Report March 2023:

The Council was commissioned by Queensland Health Public Health, Communicable Diseases Branch, Sexually Transmissible Infection/Blood Borne Virus (STI/BBV) unit to review all cases of congenital syphilis from 2010 to 2022. A Congenial Syphilis Working Group (CSWG) was established under the Council and consisted of a multidisciplinary team comprised of midwifery, obstetric medicine specialists), adult and paediatric infectious disease specialists, public health physicians from the Queensland Syphilis Surveillance Service (QSSS), and public health officers and epidemiologists from Communicable Diseases Branch, tasked with the following functions to:

- Conduct a retrospective case review of congenital syphilis cases diagnosed in Queensland including intrauterine fetal deaths (IUFD) and live births from 1 January 2010 to July 2022.
- Make recommendations to the QMPQC to inform change at the clinical (primary health care and specialist care), policy/systems and surveillance levels and inform the development of policy and procedures.
- Conduct ongoing case review of all future cases of congenital syphilis diagnosed in Queensland, including IUFD and live births for the life of the Northern Queensland STI Action Plan and longer if deemed necessary.

The Council published the *Queensland Maternal and Perinatal Quality Council Congenital Syphilis Working Group Report : March 2023**

*Above link will only work for those with access to Queensland health intranet.

Report Summary:

Congenital syphilis is a preventable infection, which can cause death or significant morbidity in the developing fetus and neonate. Despite reliable testing and effective treatment being available for decades, congenital syphilis has re-emerged as an issue of public health concern in Australia, including in Queensland.

This Report summarises the learnings from a review of the twenty-seven congenital syphilis cases that were notified in Queensland between January 2010 and July 2022.

This Report has made 11 recommendations and five good practice points for implementation to improve Queensland's congenital syphilis rates.

Recommendations:

1. That bedside point of care testing for syphilis is available to all mothers with no history of previous syphilis infection, to immediately determine syphilis serostatus following fetal death/stillbirth and/or in those who have not engaged in antenatal care.
2. That Queensland Clinical Guidelines recommend routine antenatal syphilis screening at 28 and 36 weeks. If the 36-week screen has been missed, or delivery is prior to 36 weeks, syphilis screening must be done at birth. These changes need to be incorporated into the Pregnancy Health Record.
3. That syphilis testing is a routine part of the assessment for the underlying cause of a stillbirth.
4. That all women are offered contraception postpartum, with a clear pathway post-birth for women to access timely sexual and reproductive health services including pregnancy choices, fertility control and birth spacing.
5. Those models of antenatal care, including outreach, be developed and implemented that specifically address the needs of women at higher risk of syphilis in pregnancy, particularly when complex social factors are also present.
6. That a management plan be developed for each woman who is diagnosed with syphilis during pregnancy, that includes a plan for treatment, monitoring, contact tracing and birth, as well as assessment of their baby in the neonatal period. Benzathine penicillin should be readily available for opportunistic management of affected patients and their sexual partners in antenatal and infectious diseases clinics, emergency departments and other outpatient settings.
7. That each HHS ensures:
    a) Staff are educated about and adhere to the Syphilis in Pregnancy guidelines to an auditable standard.
    b) Appropriate communication and co-ordination must occur between practitioners providing primary, secondary and tertiary care for mother and baby. This includes communication and co-ordination of post-discharge follow up with primary and other care providers. An interdisciplinary team within each HHS should have oversight of all cases, with a single point of accountability.
8. That Nurse Navigator positions be resourced to coordinate treatments, screening, antenatal checks, partner history recording, point of care testing (PoCT) at birth, follow up of baby screening and treatments, along with reporting cases with support from the Syphilis Expert Advisory Group, as required.
9. That all congenital syphilis cases be reported as a sentinel event (SAC1 event) and are reviewed locally via human error and patient safety (HEAPS) or an Root Cause analysis (RCA) or other type of analysis.
10. That a Syphilis Expert Advisory Group is established for Queensland, whose function is to:
    a) Provide expert advice to antenatal care providers regarding complex/difficult syphilis in pregnancy cases, and to ensure appropriate clinical care is provided.
    b) Provide a support role to HHSs in relation to recommendation 9 (above).
    c) Review congenital syphilis cases and advise HHSs and the Department of Health about potential future prevention strategies.
    d) Monitor and evaluate adherence to testing and clinical management guidelines.
11. That automated reminders on electronic medical record systems flag intervals for screening, consistent with the Queensland Pregnancy Health Record and Syphilis in Pregnancy Clinical Guideline.

Congenital Syphilis Report Outcomes:

In 2023 the CSWG, with QMPQC endorsement, recommended increased routine antenatal syphilis screening for **all women** in Queensland, regardless of their risk factors.
This recommendation was endorsed by the Queensland Maternal and Neonatal Clinical Network. The recommendation was included into statewide clinical guidelines; Queensland Maternity and Neonatal Clinical Guidelines Program: Guideline: Syphilis and pregnancy and was reflected in the Queensland Health: Pregnancy Health Record

In 2023 Queensland Health release a 5-year syphilis action plan to help reduce rates of syphilis in Queensland by 2028. Queensland Syphilis Action Plan 2023–2028: Overview.
This Queensland Syphilis Action Plan has a strong focus on Congenital syphilis: *Syphilis can pass to an unborn baby during pregnancy (known as congenital syphilis), and between 2011 and 2022, Queensland recorded the highest number of congenital syphilis cases of all states and territories.*

In creating the Queensland Syphilis Action Plan 2023–2028, all **11** recommendations made by the QMPQC in the *Queensland Maternal and Perinatal Quality Council Congenital Syphilis Working Group Report : March 2023**have been directly incorporate into the plan: Queensland Syphilis Action Plan 2023–2028

*Above link will only work for those with access to Queensland health intranet.

Educational Webinars

The final educational Webinar was conducted to disseminate findings of the Queensland Maternal and Perinatal Quality Council Report 2021: Mothers and Babies 2018–2019. These sessions highlighted the 26 recommendations made and provided areas for improvement with good practice points targeted to all clinicians working within Maternity across Queensland.

Congenital Anomalies Education Session | Thursday 16 March 2023

QMPQC | Queensland Health Intranet: Education*

Presenter	Title of presentation
Professor Leonie Callaway and Professor Ted Weaver QMPQC Co-Chairs	Welcome and overview of QMPQC
Associate Professor Tim Donovan	Congenital anomalies
Dr Diane Payton	Perinatal autopsy consent in Queensland
Professor Clare Nourse	Congenital Syphilis
Melanie McKenzie	Congenital anomalies - A patient's journey

*Above links will only work for those with access to Queensland health intranet

The Perinatal Mortality Review Kit

The Council in partnership with Patient Safety and Quality, CEQ published a suite of resources to assist clinicians and health services to in managing, analysing and sharing learnings from perinatal mortality incidents. The Toolkit's checklists and reference tools aim to assist Hospital and Health Service (HHS) staff to sensitively and methodically manage perinatal reviews, to support comprehensive system review and improve perinatal outcomes.

The purpose of this Toolkit is to support clinicians and health services to perform systematic, timely and robust perinatal mortality case reviews. The resources in this Toolkit assist health care staff to undertake standardised, local perinatal reviews and analysis.
Robust perinatal review and analysis processes will provide:

- answers for bereaved parents about whether the care they and their baby received was adequate
- learnings within health services, to recognise and respond to opportunities for improvements in care and prevent future baby deaths
- clinician disclosure where the treating clinician informs the patient of what has occurred and provides an apology
- open disclosure (for all SAC 1 and some SAC 2 incidents) where an analysis of the clinical incident is undertaken, and a structured process occurs openly between the family, senior clinician and other HHS representatives.

This Toolkit provides checklists and a step-by-step reference document to assist HHSs to conduct a review of perinatal deaths using an objective and structured process. It is recommended all maternity services utilise the resources contained in this Toolkit to:

- ✓ systematically review every perinatal death to identify the cause of death, where possible
- ✓ identify potentially avoidable deaths
- ✓ identify areas for clinical practice improvement
- ✓ determine if a formalised clinical incident management review is required i.e SAC1 level analysis
- ✓ deliver clinician disclosure
- ✓ deliver formal open disclosure (where applicable).

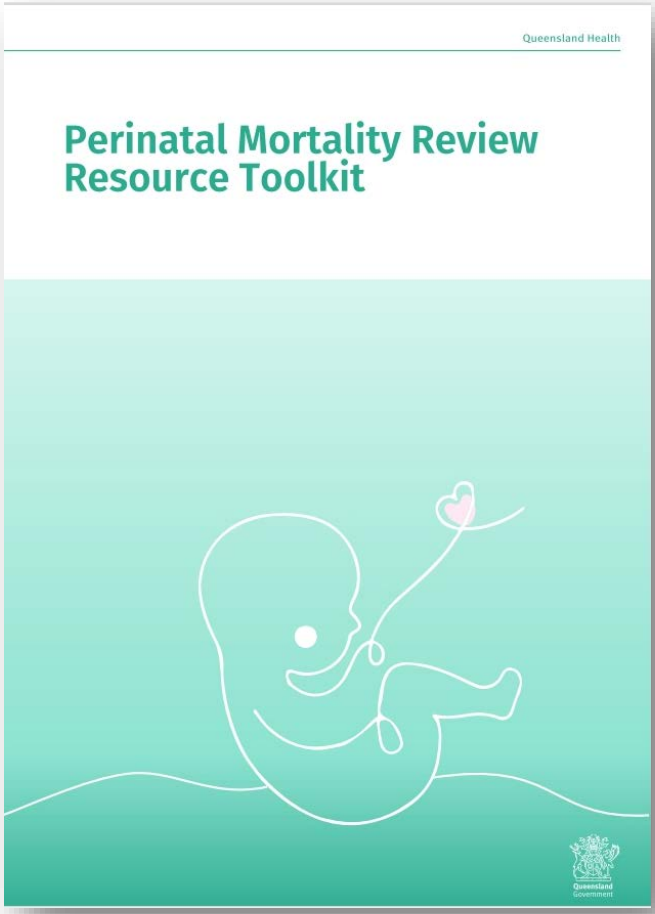
Conducting an analysis of the clinical incident is essential to identify contributing factors, obtain a greater understanding of why babies die and how to reduce the risk of death. Identifying the reason for perinatal deaths is key to improving perinatal outcomes.

The Perinatal mortality review kit was created to include all tools required to triage, perform a review, create a report, maintain a register and local data storage capture point, assign contributing factors and classify a perinatal death at the local hospital level.

A suite of perinatal mortality resources can be found on QHEPS*:
QMPQC | Queensland Health Intranet: Perinatal Mortality Review and Classification

- Intrauterine fetal death (IUFD) and Stillbirth triage checklist
- Perinatal Morbidity and Mortality meeting process map
- Perinatal and Fetal Autopsy Consent
- Contributing factors checklist
- Birthweight percentile chart for live singleton infants
- Peri_mort_HHSAudit_template (a Local HHS data storage tool
- PSANZ Perinatal Mortality Classification - Quick reference sheet
- Australian Perinatal Mortality Clinical Audit Tool (APMCAT) Section 1- Clinical data relevant to perinatal death
- Australian Perinatal Mortality Clinical Audit Tool (APMCAT) Section 2- Maternity Service Report

*Above links will only work for those with access to Queensland health intranet



Educational Webinars: Perinatal Mortality Audits

The Council presented two online interactive sessions to support clinicians' education and to provide insights into performing perinatal mortality audits. This included mock case studies to help educate clinicians in performing perinatal and neonatal mortality classifications using the Perinatal Stillbirth Australia and New Zealand (PSANZ) Classification System.
The session also emphasised the need for services to identify Contributing Factors as part of the review process and provided detailed resources including the Australian Perinatal Mortality Clinical Audit Tool (APMCAT) Section 1- Clinical data relevant to perinatal death.

QMPQC | Queensland Health Intranet: Perinatal Mortality Review and Classification*

Presenter	Title of presentation
Professor Ted Weaver QMPQC Co-Chair	Introduction
Tammy Doyle Women's and Children's Safety Improvement Support Officer Sunshine Coast University Hospital	Intrauterine Fetal Death (IUFD) and Stillbirth triage checklist
Imogen Kettle Clinical Midwife Consultant, Patient Safety and Quality, Clinical Excellence Queensland	Introduction to local HHS data storage spreadsheet

Professor Ted Weaver QMPQC Co-Chair	Case scenario 1
Professor Ted Weaver QMPQC Co-Chair	Case scenario 2
Dr Johanna Laporte Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Case scenario 3

Perinatal Mortality Audit Skill Development Webinar 1 | Thursday 20 April 2023

Presenter	Title of presentation
Professor Ted Weaver QMPQC Co-Chair	Perinatal Morbidity and Mortality meeting processes
Imogen Kettle Clinical Midwife Consultant, Patient Safety and Quality, Clinical Excellence Queenslandnbsp;	Introduction to perinatal mortality review kit
Dr Johanna Laporte Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Key challenges to running effective M&M meetings
Dr Johanna Laporte Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Case scenario

The Council facilitated a face-to-face perinatal classification workshop to assist clinicians using the PSANZ Perinatal Mortality Classification - Quick reference sheet to accurately classify a perinatal death. It highlighted commonly misclassified perinatal deaths and provided examples of how and where misclassifications are likely to occur.

An audit of the classifications of perinatal deaths was conducted and in 2022 there were 20.2 percent of deaths incorrectly classified. Following the Perinatal Webinar series and the publication of the perinatal mortality review kit*, the misclassification of cases in 2023 was reduced to only 7.5 percent of cases, a vast improvement.

QMPQC Maternity Content Matter Review Expert Register

The Council established a register of members as external, content matter review experts, available in assisting HHSs in their local Perinatal and Maternal Mortality review process. This initiative paralleled the development by of Queensland Health Incident Review External Experts register* (QHIREE) by Patient Safety and Quality, CEQ providing insight into a successful mechanism for engaging subject matter experts into clinical reviews across all specialties, including maternity.

The QHIREE register is being established to provide a register of subject matter experts (SMEs) from a broad range of specialties with expert skills and knowledge to be involved in clinical incident review processes. The QHIREE register will support timely and quality incident review processes when requests are made by Hospital and Health Services (HHSs) to Patient Safety and Quality, Clinical Excellence Queensland for independent SMEs to participate in clinical incident reviews.

*Above links will only work for those with access to Queensland health intranet

QMPQC Activities and Outcomes for 2024

Report of the Queensland Maternal and Perinatal Quality Council 2023: Queensland Mothers and Babies 2020–2021

The QMPQC published the *Report of the Queensland Maternal and Perinatal Quality Council 2023: Queensland Mothers and Babies 2020–2021*

Report Summary:

- This Report focuses primarily on the 121,213 mothers who gave birth to 123,015 babies in Queensland during 2020 and 2021. This includes the 9,072 (7.5 per cent, compared to national rate of 4.9 per cent) of women who identified as Aboriginal and/or Torres Strait Islander and their 9,211 babies.
- The Report makes **15 recommendations** regarding maternity and newborn care and sets out 28 good practice points, which are of importance to all clinicians working in maternity and newborn services across Queensland.

Highlights of the report include:

- There was 96.5 per cent attendance to the recommended five or more antenatal visits for Queensland Mothers with an increase in the proportion of Aboriginal and Torres Strait Islander women attending the recommended number of antenatal visits to 90.7 per cent. Younger mothers (<20 years of age) were less likely to attend the recommend number of antenatal visits.
- Smoking at any time during pregnancy was more common among women in Queensland than nationally (11.5 per cent vs 9.9 per cent), particularly during the first 20 weeks of pregnancy (11.4 per cent vs 8.9 per cent). However, 21.1 per cent of women who smoked in the first 20 weeks did not continue to smoke after 20 weeks gestation. Of Aboriginal and Torres Strait Islander women, 37.8 per cent smoked after 20 weeks gestation. Smoking after 20 weeks gestation was associated with a 1.4 times higher risk of preterm births, after adjusting for other risk factors.
- Of the women who gave birth, there were 48.2 per cent who were overweight or obese (BMI 25 or greater), with 4.4 per cent considered to be underweight (BMI <18.5). Maternal BMI is a risk factor for pregnancy and birth complications.
- North Queensland Aboriginal and Torres Strait Islander women exhibited the highest rate of infectious syphilis notifications at 309.5 cases per 100,000, in 2021, with Queensland having 266 cases of infectious syphilis in pregnant women notified between 2010 and 2021, with 32 cases of infectious syphilis being reported in 2021. There were 26 cases of congenital syphilis reported between 2010-2021 with nine cases that resulted in intrauterine fetal death/stillbirths or died after birth, all in Aboriginal and Torres Strait Islander infants.
- The MMR of 5.8 per 100,000 births for 2020 and 2021 corresponds directly with the national rate 5.8 per 100,000 births 42 maternal deaths occurred either during pregnancy or up to one year after the pregnancy ended for the years 2020 to 2021. Ten of the 42 maternal deaths in Queensland occurred by suicide. Seven women died from malignancies and six died as a result of motor vehicle trauma. Autopsy was performed in 27 (64 per cent) of cases, with 3 cases not having a definitive diagnosis of death.
- The stillbirth, neonatal death and perinatal mortality rates in Queensland are all higher than the corresponding national rates. The Queensland 2020-2021 perinatal mortality rate was 11.2 per 1,000 births (national perinatal mortality rate 9.6 per 1,000 births) and 6.6 per 1,000 live births when Termination of Pregnancy (ToP) was excluded. The stillbirth rate was 8.0 per 1,000 births, (national stillbirth rate 7.3 per 1,000 live births), and 4.0. per 1,000 births when ToP were excluded, and neonatal mortality rate was 3.3 per 1,000 live births (national neonatal mortality rate 2.3 per 1,000 live births) and 2.6 per 1,000 live births when ToP were excluded.

- Babies born to Aboriginal and Torres Strait Islander mothers continue to have higher rates of perinatal mortality, with stillbirths and neonatal deaths occurring at approximately twice the rate for Aboriginal and Torres Strait Islander women. This can be attributed to higher rates of known stillbirth risk factors such as maternal diabetes, perinatal infection, fetal growth restriction and unexplained antepartum fetal death in Aboriginal and Torres Strait Islander women.
- In 2020-2021, spontaneous preterm birth (39.5 per cent) and congenital anomaly (30.7 per cent) were the leading causes of neonatal deaths. Contributing factors were identified in 35 cases (58.3 per cent) of the perinatal deaths reviewed (≥ 34 weeks gestation). In 16 cases (26.7 per cent) it was considered that sub-optimal care had significantly contributed to the outcome.
- In Queensland perinatal autopsy rates remain low, with less than one third of stillborn babies having had an autopsy in 2020 and 2021 (32.2 per cent), compared to the national autopsy uptake rate of 43 per cent for 2021.

This Report delves into the perinatal health landscape of Queensland, focusing on data spanning the years 2020 and 2021. A comprehensive analysis encompassing 121,213 mothers and 123,015 babies sheds light on various facets of maternal and neonatal care, including disparities, challenges, and areas for improvement.

Maternal health and pregnancy

There has been a shift in the demographic trends of mothers, with a slight increase in births among women aged 35 and above, while the proportion of teenage mothers has decreased significantly. Notably, Aboriginal and Torres Strait Islander women exhibit higher rates of teenage pregnancies.
There continues to be disparities in access to antenatal care, with higher rates of appropriate antenatal care among women in private facilities compared to public facilities or home births. There is an encouraging increase in the proportion of Aboriginal and Torres Strait Islander women accessing recommended antenatal care.
Smoking during pregnancy remains a concern, with higher rates observed in Queensland compared to national averages, particularly during the first 20 weeks of gestation. This is a critical public health issue that needs attention.

Babies and birth

Rates of preterm births and low birthweight babies have remained relatively stable over the past decade, despite many efforts to improve these outcomes.
Babies born to Aboriginal and Torres Strait Islander mothers are more likely to be small for gestational age as seen over the past eight years.
Almost one third of babies require admission to special care or intensive care nurseries, often due to preterm birth or congenital anomalies.

Congenital anomalies

Congenital anomalies are the leading cause of perinatal deaths, with notable increases observed in specific conditions over the years.
Data shows an association of congenital anomalies with maternal factors such as pregestational diabetes and advanced maternal age.

Maternal mortality

Maternal mortality, although rare, remains concerning, particularly with maternal suicide being a leading cause of death.
Data underscores the importance of mental health follow-up and highlights gaps in mental health services for perinatal women.

Perinatal mortality

Perinatal mortality rates in Queensland are higher than the national average, with disparities evident in higher rates among Aboriginal and Torres Strait Islander communities.
Stillbirths are a major concern, primarily caused by congenital anomalies. Terminations of pregnancy significantly contribute to perinatal losses recorded under PSANZ codes, with 16 percent of stillbirths remaining as unexplained, increasing for full-term stillbirths. This figure may be overestimated due to low rates of perinatal investigations.

Implementing all five bundle elements into standard antenatal care has significantly improved performance indicators without increasing induction of labour or caesarean section rates. Stillbirth rates, due to their rarity and reporting timelines, will continue to be monitored by CEQ.
Autopsy rates for stillbirths and neonatal deaths remain low, hindering comprehensive understanding and prevention efforts.

Perinatal care review

The review of perinatal deaths is the key to improving perinatal outcomes by: (a) identifying potentially avoidable deaths and (b) using the examination of clinical circumstances surrounding these deaths, to improve the safety and quality in healthcare systems. Potentially modifiable factors identified may include issues of access to care, organisational management and factors relating to health care workers. While Queensland has made important improvements in maternal and neonatal care, persistent challenges such as perinatal mortality, congenital anomalies, and maternal mental health underscore the need for continued vigilance and targeted interventions. Together, we need to ensure optimal outcomes for mothers and babies, regardless of demographic factors.

Recommendations:

1. Expand the number of sites in hospital and health services and Aboriginal and Torres Strait Islander Community Controlled Health Organisations implementing Growing Deadly Families strategy models of care.

2. Establish a Syphilis Expert Advisory Group for Queensland, to provide expert advice about antenatal care, support Hospitals and Health Services in the review of Severity Assessment Code 1 congenital syphilis cases and monitor and evaluate adherence to testing and clinical management guidelines.

3. Raise awareness of education resources on suicide safety planning and access to acute mental health services that are available to healthcare professionals who support women and families in the peripartum.

4. Raise awareness of the training and resources available to staff to prevent, identify and support the care of women experiencing family, domestic and sexual violence in the peripartum.

5. Support the continued, dedicated resourcing of additional Mother-baby units throughout Queensland.

6. Provide access to education and training resources to strengthen the capacity of health professionals to care for women with perinatal mental health and psychosocial health concerns, throughout the continuum of perinatal and postnatal care.

7. Raise awareness of pathways for patient access to perinatal mental health services throughout Queensland, including access to specialist perinatal health advice across the continuum of care.

8. Raise awareness of training and resources available to healthcare professionals for unplanned pregnancies, complex trauma and the principles of trauma informed care.

9. Incorporate guidance to ensure cervical cancer as a differential diagnosis for antepartum haemorrhage into existing Queensland Clinical Guidelines.

10. Ensure clinical training includes speculum examinations and diagnosis/exclusion of cervical cancer during pregnancy.

11. Review the Clinical Services Capability Framework - maternity module for maternity services to consider the requirement for Level 4 services to have access to obstetric medicine services.

12. In sites using electronic medical records, implement mechanisms to ensure timely data sharing between hospital providers, GPs, midwives, and women.

13. Consider amending the Queensland Coroners Act 2003 to include investigation of all maternal deaths (including late deaths), except where there is a clear and unequivocally diagnosed cause of death, for example, a known metastatic malignancy.

14. Appropriately resource Queensland Health tertiary perinatal pathology centres to perform timely, high-quality perinatal and neonatal autopsy investigations, including placenta pathology, by perinatal pathologists.

15. Standardise perinatal mortality reviews and integrate the Perinatal Mortality Clinical Audit Tool (APMCAT) into the review process. Assess contributing factors and classify mortality cases using the Perinatal Society of Australia and New Zealand (PSANZ) perinatal mortality classification system.

Report Outcomes:

Rec 1: *Expand the number of sites in Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations implementing Growing Deadly Families (GDF) Strategy 2019-2025 models of care.*
OCMwO: There are currently 12 Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019-2025 sites across Queensland (six HHSs and six Aboriginal and Torres Strait Islander community-controlled health organisations. Data from selected sites demonstrates positive outcomes including increased number of antenatal visits for First Nations pregnant women and a reduction in low-birth weight babies. The GDF program has funded an additional three HHSs in 2024.
Rec 2: *Establish a Syphilis Expert Advisory Group for Queensland, to provide expert advice about antenatal care, support Hospitals and Health Services in the review of Severity Assessment Code 1 (SAC1) congenital syphilis cases and monitor and evaluate adherence to testing and clinical management guidelines.*
Public Health STI/BBV: The Minister did make the decision to conclude the Sexual Health Ministerial Advisory Committee at the conclusion of its current term (end March 2025) and approved that the Department establish a Sexual Health Departmental Advisory Committee (SHDAC). An initial meeting held in early April 2025, with ToR and membership still being worked through ahead of a subsequent meeting in the coming months. This committee was proposed to be chaired by the Deputy Director General Queensland Public Health & Scientific Services however this will transition across to the Chief Health Officer/DDG Population Health Division when it is established on 1 July 2025. Noting that the Sexual Health Clinical Network continues to operate in CEQ, and the chairs are proposed to be represented in the SHDAC, combined with QSSS north and south also instrumental operationally in the syphilis space.
The Council: The Council reinstated the CSWG, and are reviewing all congenital syphilis cases notified to NOCS and all cases reported to PSQ via clinical incident management.
Other key successes, relevant to the Council's recommendations:

- An update to the Patient Safety Health Service Directive (HSD) which included a protocol for reporting congenital syphilis cases was released September 2024. Health Service Directive (QH-HSDPTL-032-7), *'HHSs will conduct an analysis of all congenital syphilis cases, irrespective of whether it is considered to be a clinical incident or not, and submit a report to the PSQ, CEQ within 90 calendar days of confirmation of a congenital syphilis case by serology, PCR or other relevant investigations. This includes stillbirths and intrauterine fetal deaths where a mother/birthing parent has been diagnosed with infectious syphilis'.*

- Targeted communications have been sent to health providers regarding the addition of routine testing three times during pregnancy to the Syphilis in Pregnancy Guidelines.
- Inclusion of syphilis testing intervals and prompts in ieMR have been drafted and recently considered by the Statewide Digital Maternity Advisory Group (decision pending).

Rec 3: *Raise awareness of the training and resources available to staff to prevent, identify and support the care of women experiencing family, domestic and sexual violence in the peripartum.*
Dept of Justice (DoJ): The Domestic and Family Violence (DFV) Specialist Health Workforce Program builds the capability of the frontline health workforce to respond to DFV through the delivery of training by specialist DFV clinicians. The DFV Toolkit includes antenatal screening for domestic and family violence guideline for Queensland Health professionals involved in providing care to women during the antenatal period.
Queensland Health clinicians participate in High-Risk Teams in 10 locations across Queensland to ensure an integrated response to victim-survivors and children who are at high risk of serious harm.
Rec 4: *Support the continued, dedicated resourcing of additional Mother-Baby units throughout Queensland.*
Queensland Health: Catherine's House is Queensland's first integrated perinatal mental health center. $39 million was announced as additional new investment to boost perinatal mental healthcare and deliver 30 additional public inpatient mental health mother-baby beds in six locations – Townsville, Cairns and Hinterland, Logan, Sunshine Coast, Ipswich and South Brisbane, to be implemented from mid-2024 to late 2026.
Rec 5: *Provide access to education and training resources to strengthen the capacity of health professionals to care for women with perinatal mental health and psychosocial health concerns, throughout the continuum of perinatal and postnatal care.*
OCMwO and QCPIMH: The first Queensland Perinatal Mental Health Clinical Guideline has been developed and was published on the Queensland Health Clinical Guidelines website on 4 April 2024. Information has been circulated to stakeholders. This new guideline will raise awareness of perinatal mental health issues and provide evidence-based guidance regarding screening (including culturally appropriate screening), assessment, referral pathways, recommended follow-up and other necessary psychosocial consultation in relation to the mental health care for women, fathers and partners during pregnancy, birth and the postpartum period and provides a consistent framework to guide clinicians in delivering perinatal mental health services.
Rec 6: *Raise awareness of pathways for patient access to perinatal mental health services throughout Queensland, including access to specialist perinatal health advice across the continuum of care.*
OCMwO and QCPIMH: The implementation of perinatal mental health screening using the iCOPE screening tool has commenced. Implementation of the screening tool, iCOPE, is in 42 services across 90 locations in Queensland. The Queensland Centre for Perinatal and Infant Mental Health has increased statewide capacity including for ePIMH telepsychiatry with a focus on regional, rural, and remote areas through new funding of $2 million over five years under Better Care Together.
Rec 7: *Raise awareness of training and resources available to healthcare professionals for unplanned pregnancies, complex trauma, and the principles of trauma informed care.*
OCMwO, QCPIMH and Women's and Girl's strategy: Better Births with Consent (funded through the Women and Girls Strategy) is accessible to clinicians from every HHS annually for 4 years to support the principles of trauma informed care. Multidisciplinary Birth Education is funded through the Queensland Birth Strategy. The train the trainer program is being rolled out across Queensland to support healthcare professionals in providing complex and trauma informed care.
Rec 8: *Raise awareness of training and resources available to healthcare professiona*ls for unplanned pregnancies, complex trauma and the principles of trauma informed care.
OCMwO, QCPIMH, Women's and Girl's strategy: Better Births with Consent (funded through the Women and Girls Strategy) is accessible to clinicians from every HHS annually for 4 years to support the principles of trauma informed care. Multidisciplinary Birth Education is funded through the Queensland Birth Strategy. The train the trainer program is being rolled out across Queensland to support healthcare professionals in providing complex and trauma informed care.
Trauma informed courses – face to face: PIPE MC training includes simulated role play 1 hour trauma informed care workshop.
Rec 11: *In sites using electronic medical records, implement mechanisms to ensure timely data sharing between hospital providers, GPs, midwives, and women.*

A/Deputy Director General eHealth Queensland: The Pregnancy Health Record (PHR), the paper version has been finalised, as such a new section iView band was developed in the Maternity module within the integrated electronic Medical Record (ieMR).

Rec 12: *Review the Clinical Services Capability Framework - maternity module for maternity services to consider the requirement for Level 4 services to have access to obstetric medicine services.*

QMPQC and QMNCN requesting the CSCF Governance Committee review the CSCF Maternity Module: The Queensland Maternity and Neonatal Clinical Network (QMNCN) have endorsed the recommendation. The Office of the Chief Health Office is looking forward to reestablishing the Clinical Services Capability Framework Governance Committee and is taking the necessary steps to do so.

Rec 13: *Consider amending the Queensland Coroners Act 2003 to include investigation of all maternal deaths (including late deaths), except where there is a clear and unequivocally diagnosed cause of death, for example, a known metastatic malignancy.*

Under consideration by the Attorney General.

Rec 14: *Appropriately resourcing and follow-up with Queensland Health tertiary perinatal pathology centers to ensure that timely, high-quality perinatal and neonatal autop*sy investigations, including placenta pathology, can be conducted by perinatal pathologists.

QPHaSS: Pathology Queensland has established three expert perinatal pathology centers at The Royal Brisbane and Women's Hospital (RBWH), the Gold Coast University Hospital (GCUH) and the Sunshine Coast University Hospital (SCUH) to perform perinatal autopsies and deliver timelier and patient centric services. An additional specialist perinatal pathologist has been appointed. Two (1.6 FTE) perinatal loss coordinators have been appointed (0.8 SCUH and 0.8 RBWH)

Rec 15: *Standardise perinatal mortality reviews and integrate the Perinatal Mortality Clinical Audit Tool (APMCAT) into the review process. Assess contributing factors and classify mortality cases using the Perinatal Society of Australia and New Zealand (PSANZ) perinatal mortality classification system.*

QMPQC, PSQ CEQ: QMPQC in conjunction with Patient Safety and Quality, CEQ have scheduled education sessions to promote and guide clinicians and Patient Safety Officers in standardising perinatal mortality process and to identify contributing factors in 2025.

Review of selected 2022 Perinatal Deaths: Stillbirths (< 28 weeks) and Neonatal deaths (<22weeks)

The Council in collaboration with Patient Safety and Quality, CEQ were requested to perform a chart audit of stillbirths (<28 weeks' gestation) and neonatal deaths at 20-21 weeks' gestation to determine if there were any common contributing factors following on from the public release of Australian Institute of Health and Welfare (AIHW) preliminary 2022 data tables from the National Perinatal Data ollection (NPDC) demonstrated an increase in the perinatal mortality rate for Queensland, from 10.8 per 1,000 births in 2021 to 12.3 per 1,000 births in 2022. The rise was driven by an increase in stillbirths less than (<) 28 weeks and neonatal deaths between 20-21 weeks' gestation (this could also be described as an increase in late miscarriages).

The Minister requested a response to the Report on Government Services (ROGS) data released 2 February 2024 which demonstrated an increase in the Queensland Perinatal Mortality rate from 10.1/1,000 births in 2021 to 11.5/1,000 births in 022 and Queensland having the second highest perinatal mortality of all jurisdictions.

A report was published based on the finding of a 158 cases reviewed. The review was conducted using a combination of administrative data and patient information derived from medical records. This approach enabled a high degree of confidence in the review findings. However, it should be noted that reviewing a single year of data makes it difficult to determine the significance of findings, and there is minimal empirical evidence regarding causation and preventability of perinatal deaths at these gestations.

A range of key findings are documented throughout this report, but in summary:

- There has been no increase in preventable perinatal deaths in 2022.
- There are no generalised interventions or modifiable factors which would change the outcome.
- The increase in perinatal mortality is an increase in late miscarriage, mostly at previable gestations.
- The chart audit demonstrated that the clinical care provided to this cohort in most instances, aligned with best practice.
- The contributing factors identified in the review were consistent with known stillbirth risk factors and current risk screening:
    - Lower socioeconomic status
    - Elevated Body Mass Index (BMI)
    - Age <20 years
    - Indigenous status.

In addition, when compared to stillbirths ≥28 weeks (in the third trimester), the risk for perinatal death was much higher for women with BMI > 30 and those from the most disadvantaged socio-economic indexes for areas (SEIFA) quintile.
There were two additional findings that are important, but not directly related to the causes of perinatal death:

- There is a high number of women who are not accessing the recommended antenatal ultrasound scans.
- There were a significant number of misclassifications of causes of perinatal death within the Queensland Perinatal Data Collection.

The following recommendations have been made:

- Source data from other Australian jurisdictions: (a) 2022 perinatal death numbers and (b) Perinatal Society of Australian and New Zealand (PSANZ) classifications. This will help determine whether there has been a proportional rise in perinatal mortality rates and the identified causes of death according to PSANZ classifications, across other jurisdictions.

- Conduct an audit of Queensland 2023 PSANZ classifications to quantify misclassifications and identify trends in the causes of perinatal death compared to previous years.
- Strengthen mechanisms to adjust the initial recorded PSANZ classifications once placental histology and autopsy results become available.
- Consider strategies to increase the uptake of women accessing recommended antenatal ultrasounds.
- Conduct an analysis of the rate of perinatal mortality of known risk factors (lower socioeconomic status, elevated body mass index, age less than 20 years and indigenous status) from 2018-2023 and present to the QMPQC for consideration of further potential prevention strategies.
- Advocate that the Productivity Commission use the National Perinatal Data Collection as the source of comparison of perinatal deaths in their Report on Government Services (ROGS).

Key findings

1.	There has been no increase in preventable <28-week gestation stillbirths
2.	There are no generalised interventions which would change the outcome
3.	The increase in perinatal mortality is due to an increase in late miscarriage, mostly at pre-viable gestations
4.	The chart audit demonstrated that the clinical care provided to this cohort aligned with best practice
5.	Queensland should advocate that the Productivity Commission use the National Perinatal Data Collection as the source of comparison of perinatal deaths to improve consistency and the quality of data collection in their ROGs report
6.	The leading cause of death for perinatal deaths in this review was spontaneous preterm labour or rupture of membranes. There were more deaths with this PSANZ classification than in previous years
7.	Stillbirths and neonatal deaths were associated with more chorioamnionitis than in previous years
8.	The chart audit identified that approximately 20 percent of reported PSANZ classifications were incorrect
9.	Women in this cohort appeared to be younger than the 'All QLD births' population, but not younger than women experiencing stillbirth ≥ 28 weeks
10.	Women in this cohort were more likely to have higher BMIs than all mothers who gave birth in Queensland. In addition, they were also generally in the **more** obese categories than women experiencing stillbirths at later gestations
11.	Women in this cohort were more likely to reside in the most disadvantaged localities
12.	Indigenous women within the audit cohort were over-represented in each of the stillbirth risk factors considered

13.	Women in this cohort were less likely to have had the recommended antenatal ultrasounds
14.	All women who had an antepartum haemorrhage were reviewed by a medical officer
15	All women who experienced a neonatal death and had an identified shortened cervix, received appropriate management
16.	There is no conclusive evidence to link the COVID-19 virus with perinatal mortality in this cohort

Review of selected 2022 Perinatal Deaths Outcomes:

This Report resulted in the then Minister for Health and Ambulance Services, Shannon Fentiman, allocating $3M of recurrent funding directly to the five Maternal Fetal Medicine units across Queensland Health to assist in the uptake of maternal scanning.

Queensland Health developed the Queensland Health Self-Referral Portal for pregnant women. This project was led by the Office of the Chief Midwife Office and is aimed at enhancing the timely access for women to antenatal services.

IMPROVE: Improving Perinatal Mortality Review and Outcomes via Education

In May 2021, Yvette D'Ath, the then Minister for Health and Ambulance Services, signed a schedule of funding with Commonwealth for $83,000 (as part of the National Stillbirth Action and Implementation Plan) for initiatives to increase the uptake of stillbirth autopsies and investigations. The QMPQC Perinatal Mortality Sub-committee provided advice for the provision of IMPROVE workshops to align with the funding intent. The IMPROVE face-to-face training workshops are designed to address the educational needs of health professionals involved in maternity and newborn care in managing perinatal death.

There are 6 (six) learning stations that require facilitators with specific clinical expertise.

1. Communicating with parents about perinatal autopsy
2. Autopsy and placental examination
3. Investigation of fetal death
4. Examination of babies who die in the perinatal period
5. Institutional and perinatal mortality audit and classification
6. Respectful and supportive bereavement care

The Council noted that it would be valuable to build a sustainable workforce of IMPROVE educators within Queensland Hospital and Health Services. To meet this objective, the delivery of a series of IMPROVE training programs that generated a new cohort of facilitators and provided these facilitators immediate opportunity to apply their skills, was undertaken in 2022.

Between 2022-2024, 17 IMPROVE workshops were held in both metropolitan and regional areas through Queensland. In 2025, a further 10 IMPROVE workshops have been scheduled. There have been approximately 350 clinicians attend these workshops. Significantly, QLD now has 70 trained IMPROVE educators and include the following clinicians:

- Obstetricians
- Senior Obstetric Registrars
- Neonatology
- Midwifery
- Maternal Fetal Medicine
- Neonatal nursing
- Social work

- Pathology

The Council was instrumental in the endorsement and recruitment of facilitators and educators for the IMPROVE program.

QMPQC Matters Series:
Maternity Matters: Edition 01 October 2024

As part of the commitment to continuous improvement in maternity care, the Council has developed the Matters Series—a collection of concise, practical factsheets designed specifically for clinicians working across maternity services in Queensland.
These publications distil key issues, findings, and learnings from case reviews into accessible insights. To maintain confidentiality, each factsheet uses fictional clinical scenarios that reflect clinical case challenges and offers context for generation of good practice points, strategies and clinical considerations.
The Matters Series is available on the *Queensland Maternal and Perinatal Quality Council | Clinical Excellence Queensland* and ensures that valuable learnings reach those delivering care on the ground. These publications are distributed via the Queensland Health intranet, direct mailouts to Queensland HHSs maternity units and departments, private maternity facilities, GPs and private obstetricians.

The Council membership

Chairs(s) and Co-Chairs

Membership	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Professor Leonie Callaway (Co-Chair)	2010	MBBS (Hons I) FRACP PhD GCE Lead GAICD	Director of Research, Women's and Newborn Services; Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Professor Leonie Callaway is an 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.
Professor Ted Weaver (Co-Chair)	2010	OAM MBBS, FRANZCOG, FACM (Hon)	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service, Professor of Medical Education, QUT	Edward (Ted) Weaver is a Senior Medical Officer in the Department of Obstetrics and Gynaecology at the Sunshine Coast University Hospital. He was a Clinical Sub-Dean Griffith University School of Medicine Sunshine Coast. He is a Professor in Obstetrics and Gynaecology at both University of Queensland and Griffith University. Dr Weaver was Vice President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) from 2006, and President from 2008, during a time of significant maternity care reform in Australia. Ted holds an Order of Australia Medal.

Council Members

Membership Council	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Dr Sarah Tozer	2021	BSc-Med Sci, PhD	QMPQC Coordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland	Dr Sarah Tozer is the principal project officer responsible for coordinating all functions and activities for the QMPQC. Her background is in molecular, diagnostic, translation research in area of infectious diseases, particularly paediatric infectious diseases. Sarah has worked across multiple services, with numerous stakeholders from private enterprise, universities, industry, and public healthcare.
Dr Johanna Laporte (PMSC Chair)	2015	MBBS FRANZCOG, CMFM	Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Johanna is a full time Maternal fetal medicine specialist. Her experience extends into managing bereaved families in a very large clinical setting. She is the Chair of the RWBH perinatal mortality meeting and has been since 2015.
Dr Nikki Whelan (MMSC Chair)	2002	MBBS, FRANZCOG	Private Consultant Obstetrician & Gynaecologist	Dr Whelan is a member of SOMANZ, ISOM, NASOM, ISSHP, ADIPS, AND IADPSG, and actively participates in their regular meetings and congresses. Since 2002 Nikki Whelan has been a member of the Queensland Maternal and Perinatal Committee. Also a member of the Maternal Mortality Sub-Committee and currently and chair this meeting, and member of the Perinatal Mortality Sub-Committee.
Dr Renuka Sekar (CASC Chair)	2010	MBBS, Dip. Gynecology and Obstetrics, FRANZCOG, CMFM	Clinical Lead, Maternal and Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Renuka Sekar is Senior Staff specialist Obstetrics and Subspecialist Clinical Lead Maternal and Fetal Medicine. Senior Lecturer at UQ since 2009. Vast experience in managing complex pregnancies, teaching, research and training. Actively involved with Queensland Guidelines especially aneuploidy and genetic screening in pregnancy.
A/ Professor Tim Donovan	2011	MBBS, FRACP, Masters Public Health	Neonatal Medicine and Consultant Neonatology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Tim has served on the steering committee since February 2014 and has been Chair of the Congenital Anomalies Subcommittee from 2019 to 2024. Tim provides insight into the perinatal care of newborns from a tertiary neonatal facility as well as contributing significantly to regional assessments of perinatal outcomes in Queensland.
Joanne Ellerington	2013	B Bus Health Information Management	Manager Data Collections, Statistical Collections and Integration Unit, Statistical Services Branch, Healthcare Purchasing and System Performance Division	Joanne Ellerington is the Manager of the Queensland Perinatal Data Collection (QPDC), Queensland Perinatal Mortality Data Collection (QPMDC), Queensland Maternal Mortality Data Collection (QMMDC), Queensland Hospital Admitted Patient Data Collection (QHAPDC) as well as the Queensland Birth registration Data Collection (QBRDC) and Queensland Death Registration Data Collections (QDRDC). Her background is in providing trusted statistical data and information, meta data standards, statistical reporting, and analytics to meet official reporting requirements to enable funding recoupment and to create an

				evidence base for informed decisions that improve health and health service delivery.
Imogen Kettle	2018	RN/RM, BNu,Mast (Research) Ed	Clinical Midwife Consultant-Perinatal Mortality Projects, Patient Safety and Quality, Clinical Excellence Queensland.	Imogen Kettle is a Clinical Midwife Consultant with expertise in perinatal case review, pregnancy care, research, audit, and education. She coordinates projects analysing serious adverse maternal and perinatal incidents and supports maternity services with their own incident reviews. Imogen has worked in research and has a background in tertiary and health service education, advancing the learning of student midwives. She has over 30 years of midwifery experience which included practicing in an Outreach Community pregnancy care clinic and teaching childbirth and parenting education.
Dr Diane Payton	2011	MBBS, FRCPA	Anatomical Pathologist, Pathology Queensland	Diane is a perinatal anatomical pathologist at Queensland Pathology, Herston. She has special interests in the unexplained late gestation/term intra-uterine death of normal appearing well grown infants. She is currently Chair of the Paediatric Advisory Committee for RCPA and in this position attended and presented at the Senate enquiry into Stillbirth and advocated for detailed high-quality autopsies performed by specialised perinatal pathologists.
Marcia Morris	2020	Registered Nurse	Nursing and Midwifery Director	Marcia Morris is the Nursing and Midwifery Director for Women, Children and Family Services at Caboolture Hospital. She has a broad knowledge of contemporary nursing and midwifery practice and a background in Safety and Quality and Clinical Informatics. Marcia has worked across multiple private and public organisations and is passionate about safe, quality consumer focused maternity services.
Dr Melissa Cairns	2020	MBBS FRACGP GAICD	"Specialist General Practitioner, Ashgrove, Brisbane. Chair Metro North Hospital and Health Board Safety and Quality Committee."	Dr Melissa (Meg) Cairns is a Specialist General Practitioner with specific interest and experience in the health of women, children, and families. Meg is an experienced non-executive board director.
Anne Bousfield	2016	B Nursing, Master of Midwifery, Neonatal Intensive Care Nurse, Lactation Consultant	Director of Midwifery - South West Hospital Health Service	Anne Bousfield is a midwife who has worked in a broad range of maternity/neonatal care from rural and remote, regional, tertiary services and has experience as a privately practicing midwife and Neonatal Intensive Care Nurse. She managed the transitioning of the 3 x Level 3 SWHHS maternity services from ward-based models to Midwifery Group Practices and continues to manage governance of maternity services across the SWHHS. Anne provides a rural and remote maternity lens to a number of statewide networks and steering groups.

Pauline McGrath	2016	MNursLead, FHGSA	Principal Genetic Counsellor Children's Health Queensland	Pauline is a Human Genetics Society of Australasia registered Genetic Counsellor. She has been the genetic counselling clinical lead for prenatal and fetal medicine genetic counselling services for Queensland until 2024 when she was appointed Principal Genetic Counsellor CHQ to establish in house genetic counselling for QCH. In 2013 she was awarded a Churchill Fellowship to explore the provision of counselling support for women accessing emerging pre-natal testing technologies. She has also been involved in the development of national guidelines and Queensland Clinical guidelines for screening and diagnosis in pregnancy
Dr Lucy Cooke	2020	BMed Sci, MBBS, FRACP	Neonatologist and Medical Director, Neonatal Retrieval Service – Southern and Central Queensland and Northern New South Wales, Metro North Hospital and Health Service	Dr Lucy Cooke is a specialist Paediatrician and Neonatologist and joined the RMHC SEQ Board in May 2021. Lucy is a medical graduate of The University of Nottingham (UK) and holds a Fellowship at the Royal Australian College of Physicians. She is currently the Medical Director of NeoRESQ, a neonatal retrieval service for South-East Queensland. In the 17 years prior to that, Lucy held a range of senior positions at the Mater Mother's Hospital, including Director of Neonatology, and has served and currently serves on a range of state and national committees relating to neonatology, maternity, and paediatrics. Lucy brings a wealth of knowledge and experience in the hospital and health system and the care of children and families to the Board.
Courtney Hala	2023	BSocSc, BMid, GDipHealthPro	Statewide Aboriginal and Torres Strait Islander Perinatal and Infant Mental Health Coordinator, Child and Youth Mental Health Service, Children's Health Queensland	Courtney is a registered midwife and a strong, proud Aboriginal Wiradjuri woman who actively participates in her local (Brisbane North) Aboriginal community. Her role as a Clinical Midwife Consultant with Children's Health Queensland is a testament to her dedication to Aboriginal and Torres Strait Islander health, where she focuses on supporting families with cultural sensitivity and emotional intelligence. With over three years of coordinating perinatal and infant mental health services statewide, she has honed her expertise in workshop facilitation and communication, ensuring that families receive culturally competent care.
Dr Joanne Frost	2023	MBBS, BAppSci (ExSpSci) HONS I, Grad Cert Biostatistics, O&G Registrar, RANZCOG	O&G Registrar, Gold Coast University Hospital. Project officer, Women's and Newborn Services, Royal Brisbane and Women's Hospital. PhD Candidate, The University of Queensland.	Dr Joanne Frost is an Obstetrics and Gynaecology registrar and PhD candidate. Her PhD research is focused on Severe Acute Maternal Morbidity (SAMM). Her work aims to quantify the burden of disease in Queensland, assess recording and reporting systems for SAMM data, and future implications include minimising preventable adverse maternal outcomes. Her experiences as a clinician and researcher provides her with in depth knowledge of issues relating to maternal morbidity and mortality.

Dr Huda Safa	2022	MBChB Dip O & G Auckland Uni, FRANZCOG	Senior Staff Specialist, Obstetrics and Gynaecology, Mater Mothers Hospital	Dr Huda Safa is senior Obstetrician with significant experience in high-risk obstetrics, medical disorders in pregnancy and infections in pregnancy She is the Mater Obstetric Lead for medical high- risk obstetric MDT and the Infections in Pregnancy MDT. She is the current Medical Lead for Ambulatory Services, including oversight of Mater-GP shared care alignment program.
Cherie Boniface	2023	GrdCert Nursing GrdCert Midwifery GrdCert Neonatal Nursing	Clinical Midwifery Consultant, Maternal Fetal Medicine Townsville University Hospital, Townsville Hospital and Health Service	Cherie is a registered nurse/midwife with extensive Neonatal nursing experience and currently holds a position at Townsville University Hospital as the Clinical Midwifery Consultant for Maternal Fetal Medicine since May 2013. During this period she has been preparing and classifying case reviews for our Perinatal Mortality Meetings at the Townsville University Hospital. As part of this process, we investigate contributing factors related to each case and determine if there are avoidable or preventable factors and recommend and implement changes and improve outcomes for mothers and babies in our region. Cherie is an IMPROVE educator and her special interest area is perinatal mortality classification. Cherie provides insight into maternity care for the Northern Region of Queensland. Cherie is a neonatal nurse and is the Clinical Midwifery Consultant in NQ Maternal Fetal Medicine. She has been working in this area for the last 13 years. Cherie has previously worked a research midwife at the Townsville Hospital and as a Clinical Nurse in the Neonatal Unit.
Dr Jake Parker	2024	MBBS, FRACGP, FACRRM, DRANZCOG (Ad)	Senior Medical Officer - GP Obstetrician, Thursday Island Hospital, Torres and Cape Hospital and Health Service	Jake is a GP Obstetrician with an interest in maternity care in rural and remote areas, Aboriginal and Torres Strait Islander Healthcare, and health equality. In addition to his clinical work, he focuses on case reviews and healthcare system improvement. He has worked across Far North Queensland, Darwin, northern Western Australia, and Papua New Guinea. He lives and works in the Torres Strait.
Dr Simone Naughton	2024	RM RN PhD	Assistant Director of Midwifery – Maternity Appraisal Project Strategy and Investment Unit, Torres and Cape Hospital and Health Service	Dr Simone Naughton is a midwife with extensive experience working in clinical and leadership roles across remote, rural, regional, and tertiary health services in Australia and internationally. Simone has more than 5 years' experience as a steering committee member of several Queensland initiatives and clinical networks that support quality and safety in maternity services. Simone has completed a PhD focusing on woman centered care in complex pregnancy situations.
Dr Kat McLean	2025	BMedSci, MBChB, FRACGP, FRNZCGP	Senior Medical Officer, Coomera Integrated health and wellbeing hub, Kalwun Development Corporation	Dr Katrina McLean is the Senior Medical Officer of the Gold Coasts' Community Controlled Aboriginal Medical Service, Kalwun Health Service. Dr McLean has contributed her expertise on numerous local, regional, and national entities. These roles have included, Chair of General Practice Gold Coast, Institute of Urban Indigenous Health Clinical Governance Committees, Gold Coast Council member of the Qld AMA, and faculty member of the Royal

				Australian College of General Practitioners (RACGP). Dr Katrina Mclean has extensive experience in leadership and advocacy, mentoring students, registrars, and fellow doctors.
Ahlia Griffiths	2023		Consumer Representative	Consumer Representative
Jenna Fletcher	2023		Consumer Representative	Consumer Representative
Kirstine Sketcher-Baker	2022	ex-officio	ex-officio as Executive Director Patient Safety and Quality, Clinical Excellence Queensland,	ex-officio as Executive Director Patient Safety and Quality, Clinical Excellence Queensland,
Amanda Ostrenski	2020	ex-officio	ex-officio as Queensland Maternal Neonatal Clinical Network Co-Chair	ex-officio as Queensland Maternal Neonatal Clinical Network Co-Chair
Dr Peter Ganter	2020	ex-officio	ex-officio as Queensland Maternal Neonatal Clinical Network Co-Chair	ex-officio as Queensland Maternal Neonatal Clinical Network Co-Chair
Liz Wilkes	2024	ex-officio	ex-officio as Chief Midwife Officer, Office of the Chief Midwife Officer, Clinical Excellence Queensland	ex-officio as Chief Midwife Officer, Office of the Chief Midwife Officer, Clinical Excellence Queensland
Melina Connors	2024	ex-officio	ex-officio as First nations Midwifery director, Office of the Chief Midwife Officer, Clinical Excellence Queensland	ex-officio as First nations Midwifery director, Office of the Chief Midwife Officer, Clinical Excellence Queensland
Professor Rebecca Kimble	2020	ex-officio	ex-officio as Queensland Clinical Guidelines	ex-officio as Queensland Clinical Guidelines
Diane Cruice	2023	ex-officio	ex-officio Queensland Paediatric Quality Council secretariat	ex-officio Queensland Paediatric Quality Council secretariat
Jodie Osborne	2023	ex-officio	ex-officio Queensland Paediatric Quality Council secretariat	ex-officio Queensland Paediatric Quality Council secretariat

Maternal Mortality subcommittee	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Dr Nikki Whelan (Chair)	2010	MBBS, FRANZCOG	Private Consultant Obstetrician & Gynaecologist	Dr Whelan is a member of SOMANZ, ISOM, NASOM, ISSHP, ADIPS, AND IADPSG, and actively participates in their regular meetings and congresses. Since 2002 Nikki Whelan has been a member of the Queensland Maternal and Perinatal Committee. I am a member of the Maternal Mortality Sub-Committee and currently chair this meeting and am a member of the Perinatal Mortality Sub-Committee.
Professor Leonie Callaway	2010	MBBS (Hons I) FRACP PhD GCE Lead GAICD	Director of Research, Women's and Newborn Services; Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Professor Leonie Callaway is an 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.
Dr Sarah Tozer	2021	BSci-Med Sci, PhD	QMPQC Co-ordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland	Dr Sarah Tozer is the principal project officer responsible for coordinating all functions and activities for the QMPQC. Her background is in molecular, diagnostic, translation research in area of infectious diseases, particularly paediatric infectious diseases. Sarah has worked across multiple services, with numerous stakeholders from private enterprise, universities, industry, and public healthcare.
Professor Ted Weaver	2010	OAM MBBS, FRANZCOG, FACM (Hon)	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service, Professor of Medical Education, QUT	Edward (Ted) Weaver is a Senior Medical Officer in the Department of Obstetrics and Gynaecology at the Sunshine Coast University Hospital. He was a Clinical Sub-Dean Griffith University School of Medicine Sunshine Coast. He is a Professor in Obstetrics and Gynaecology at both University of Queensland and Griffith University. Dr Weaver was Vice President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) form 2006, and President from 2008, during a time of significant maternity care reform in Australia. Ted holds an OAM.
Dr Simon Maffey	2015	MBBS, FANZCA, Grad Cert Health Management (QH)	Acting Clinical Director Anesthesia, Mater Health Service South Brisbane	Dr Simon Maffey is a senior anaesthetist with experience in regional and metropolitan hospitals. He is currently Acting Clinical Director, Anaesthesia at Mater Health Service, including Mater Mothers Hospital, with a substantive appointment as Deputy Director, Obstetric Anaesthesia since 2012.

Dr Rebecca Williams	2011	BSc, MBBS (Hons I), FRCPA	Regional Director Forensic Pathology, Forensic & Coronial Services, Townsville University Hospital, Townsville Hospital and Health Service	Rebecca has been a specialist forensic pathologist since January 2008, having worked at worked at Coopers Plains, Toowoomba, and Townsville, with a strong interest in maternal deaths, as well as childhood non-accidental injury, deaths in custody and First Nations people in the Coronial system.
Dr Susan Roberts	2010	MBBS (Hons) FRANZCP	Perinatal Psychiatrist Gold Coast Perinatal and Infant Mental Health Service and Clinical lead Lavender Mother and Baby Unit	Dr Susan Roberts is a Senior Medical Officer at Gold Coast University Hospital. She has worked in the subspecialty of Perinatal Psychiatry for the last 25 years across private practice, Consultation and liaison psychiatry, Perinatal mental health outpatient service and Lavender Mother and Baby unit inpatient setting. She is a committee member for the Section of Perinatal Psychiatry for the Royal Australia and New Zealand College of psychiatrists and is on the committee for the National Mother and Baby Units. She is an active member of the Australasian and International Marce Society for Perinatal mental health and a member for the newly formed Australian Maternal Mental Health Alliance.
Dr Fiona Britten	2020	FRACP Obstetric Medicine Qualification, MBBS, BA/BSc	Endocrinologist and Obstetric Physician, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Fiona is currently undertaking a PhD examining the rate of breastfeeding in mothers with type 2 diabetes and the role of impaired secretory activation in lactation establishment. Fiona has been a member as a clinical lead on: Bariatric Surgery in Pregnancy QLD Clinical Guideline Working Group pub. August 2021, Queensland Perinatal Quality Council 2020-2022, member of working group and co-author of 2019 Australian Diabetes in Pregnancy Pregestational Diabetes Management Guidelines.
Dr Melissa Cairns	2020	MBBS FRACGP GAICD	Specialist General Practitioner, Ashgrove, Brisbane. GP Liaison Officer Metro North Health and Brisbane North PHN, Deputy Chair Metro North Hospital and Health Board, Chair Metro North Hospital and Health Board Safety and Quality Committee.	Dr Melissa (Meg) Cairns is a Specialist General Practitioner with specific interest and experience in the health of women, children, and families. Meg is an experienced non-executive board director.

Catherine Rawlinson	2019	BBehavSc, BPsych Hons	Service Development Leader, Queensland Centre for Perinatal & Infant Mental Health, Children's Health Queensland Hospital and Health Service	Cate Rawlinson is a psychologist with a background in child and youth mental health, child protection, adult and older persons mental health. Cate has worked in the QCPIMH Strategy Team for the past 14 years focusing on perinatal and infant mental health service development and implementation and service system growth, workforce development, mental health promotion and prevention and research and service evaluation.
Dr Shane Townsend	2023	MBBS, FANZCA, FCICM, EMBA, PGDipCU	Director of Intensive Care, Royal Brisbane and Women's Hospital.	Dr Townsend was the former Director of ICU at the Mater Hospital Brisbane from 2010-2018 and subsequently the Director of ICU at the RBWH from April 2018 to the current date. Dr Townsend has significant experience in obstetric critical care. He has also been Chair of the Resuscitation Committee at the Mater Hospital South Brisbane and the Deteriorating Patient Committee RBWH.
Therese de Dassel	2021	BSc(Hons) MClinPsych	Advanced Psychologist, Perinatal Wellbeing Team, Mental Health, Metro North Hospital and Health Service	Therese de Dassel has worked in public and private mental health settings, and within perinatal mental health services since 2009. Therese has a track record in clinical research relating to maternal reflective functioning, perinatal PTSD, nightmares in PTSD, posttraumatic growth, and preterm babies intellectual and behavioral development.
Marcia Morris	2020	Registered Nurse, Registered Midwife, BSc Honours - Midwifery	Nursing and Midwifery Director Women, Children and Families Caboolture, Kilcoy and Woodford Directorate	Marcia Morris is the Nursing and Midwifery Director for Women, Children and Family Services at Caboolture Hospital. She has a broad knowledge of contemporary nursing and midwifery practice and a background in Safety and Quality and Clinical Informatics. Marcia has worked across multiple private and public organisations and is passionate about safe, quality consumer focused maternity services.
Dr Tegan Triggs	2023	BSc MBBS FRANZCOG	Consultant Obstetrician Gynaecologist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service, PhD candidate	Tegan Triggs is an obstetrician and fellow in maternal fetal medicine at Royal Brisbane and Women's Hospital, with a clinical interest in perinatal mental health and maternal medicine. She is in the final year of her PhD which has explored strategies for predicting and preventing adverse perinatal outcomes in small for gestational age infants, and her research interest is in placental dysfunction and perinatal trials.
Dr Simone Naughton	2024	RM RN PhD	Assistant Director of Midwifery – Maternity Appraisal Project Strategy and Investment Unit, Torres and Cape Hospital and Health Service	Dr Simone Naughton is a midwife with extensive experience working in clinical and leadership roles across remote, rural, regional, and tertiary health services in Australia and internationally. Simone has more than 5 years' experience as a steering committee member of several Queensland initiatives and clinical networks that support quality and safety in maternity services. Simone has completed a PhD focusing on woman centered care in complex pregnancy situations.

Tracey Mackle	2024	Master Mental Health Nursing; Master Nursing Science (Nurse Practitioner)	Mental Health Nurse, Nurse Practitioner Perinatal Wellbeing Team, Mental Health, Metro North Hospital and Health Service	Tracey is a front-line clinician working with pregnant women and postnatal mothers with moderate to severe perinatal mental health conditions. She has over 15yrs experience working in perinatal mental health space, with research completed in perinatal trauma and perinatal PTSD.
Claire Paterson	2024	MSc Health Practice, BScN BSc Psychology & Criminology (Hons)	Clinical Nurse Consultant, Perinatal Mental Health Gold Coast University Hospital, Gold Coast Hospital and Health Service	Claire Paterson is a clinical nurse consultant specialising in mental health with a focus on perinatal and infant mental health. Her background is the assessment and management of mental health conditions, delivering person centered care and implementing strategies to improve maternal health outcomes.
Dr Kylie Burns	2024	B.MED, FRACP-Cardiology	Senior Medical Officer ACHD TPCH, Obstetric Medicine Cardiologist RBWH	Kylie is and adult Congenital Heart Disease Specialist at TPCH with an interest in cardiac disorders in pregnancy.
Dr Jake Parker	2024	MBBS, FRACGP, FACRRM, DRANZCOG (Ad)	Senior Medical Officer - GP Obstetrician, Thursday Island Hospital, Torres and Cape Hospital and Health Service	Jake is a GP Obstetrician with an interest in maternity care in rural and remote areas, Aboriginal and Torres Strait Islander Healthcare, and health equality. In addition to his clinical work, he focuses on case reviews and healthcare system improvement. He has worked across Far North Queensland, Darwin, northern Western Australia, and Papua New Guinea. He lives and works in the Torres Strait.
Dr Sarah Maguire	2024	BSc, MBBS, FANZCA	Staff specialist Anaesthetics and Obstetric Lead - Mater Mother's Hospital	Sarah has a special interest in Obstetric Anaesthetics, specifically high-risk patients and I am the Mater Mother's anaesthetic representative on the High-Risk Obstetrics multi-disciplinary team. I have a special interest in Obstetric Anaesthetics, specifically high-risk patients and I am the Mater Mothers anaesthetic representative on the High-Risk Obstetrics MDT.
Tara Denaro	2023	B Nu, Dip- Mid Cert- Nu Peads	Clinical Nurse Consultant, Strong Start to Life, Aboriginal and Torres Strait Islander Leadership Team, Metro North Hospital and Health Service	Tara is a First Nations women working in maternity across Metro North. She is a member of · the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, a member of QNMU Aboriginal and Torres Strait Islander Reference Group and a Member of Australian College of Midwives.

Perinatal Mortality subcommittee	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Dr Johanna Laporte (Chair)	2015	MBBS FRANZCOG, CMFM	Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Johanna is a full time Maternal fetal medicine specialist. Her experience extends into managing bereaved families in a very large clinical setting. She is the Chair of the RWBH perinatal mortality meeting and has been since 2015.
Dr Sarah Tozer	2021	BSC- Med Lab Sci,	QMPQC Co-Ordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland	Dr Sarah Tozer is the principal project officer responsible for coordinating all functions and activities for the QMPQC. Her background is in molecular, diagnostic, translation research in area of infectious diseases, particularly paediatric infectious diseases. Sarah has worked across multiple services, with numerous stakeholders from private enterprise, universities, industry, and public healthcare.
Professor Ted Weaver	2019	OAM MBBS, FRANZCOG, FACM (Hon)	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service, Professor of Medical Education, QUT	Edward (Ted) Weaver is a Senior Medical Officer in the Department of Obstetrics and Gynaecology at the Sunshine Coast University Hospital. He was a Clinical Sub-Dean Griffith University School of Medicine Sunshine Coast. He is a Professor in Obstetrics and Gynaecology at both University of Queensland and Griffith University. Dr Weaver was Vice President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) form 2006, and President from 2008, during a time of significant maternity care reform in Australia. Ted holds an OAM.
Dr Nikki Whelan	2010	MBBS, FRANZCOG	Private Consultant Obstetrician & Gynaecologist	Dr Whelan is a member of SOMANZ, ISOM, NASOM, ISSHP, ADIPS, AND IADPSG, and actively participates in their regular meetings and congresses. Since 2002 Nikki Whelan has been a member of the Queensland Maternal and Perinatal Committee. I am a member of the Maternal Mortality Sub-Committee and currently chair this meeting and am a member of the Perinatal Mortality Sub-Committee.
Professor Helen Liley	2011	MB ChB, FRACP	Senior Staff Specialist, Neonatology, Mater Health Services	Professor Helen Liley is an Honorary Senior Research Fellow of Mater Research and is co-chair of the Critical Care of At-Risk Newborns Research Group. She holds a clinical appointment as a Senior Staff Specialist in Neonatology at the Mater Mothers' Hospital.

Joanne Ellerington	2013	B Bus Health Information Management	Manager Data Collections, Statistical Collections and Integration Unit, Statistical Services Branch, Healthcare Purchasing and System Performance Division	Joanne Ellerington is the Manager of the Queensland Perinatal Data Collection (QPDC), Queensland Perinatal Mortality Data Collection (QPMDC), Queensland Maternal Mortality Data Collection (QMMDC), Queensland Hospital Admitted Patient Data Collection (QHAPDC) as well as the Queensland Birth registration Data Collection (QBRDC) and Queensland Death Registration Data Collections (QDRDC). Her background is in providing trusted statistical data and information, meta data standards, statistical reporting, and analytics to meet official reporting requirements to enable funding recoupment and to create an evidence base for informed decisions that improve health and health service delivery.
Anne Bousfield	2016	B Nursing, Master of Midwifery, Neonatal Intensive Care Nurse, Lactation Consultant	Director of Midwifery - South West Hospital Health Service	Anne Bousfield is a midwife who has worked in a broad range of maternity/neonatal care from rural and remote, regional, tertiary services and has experience as a privately practicing midwife and Neonatal Intensive Care Nurse. She managed the transitioning of the 3 x Level 3 SWHHS maternity services from ward-based models to Midwifery Group Practices and continues to manage governance of maternity services across the SWHHS. Anne provides a rural and remote maternity lens to several statewide networks and steering groups.
Deborah Birthisel	2017	BNur, Certificate-Midwifery Nursing	Clinical Midwife, Birth Suite, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Deborah Birthisel is a Senior Clinical Midwife at Royal Brisbane and Women's Hospital. She has over 29 years' experience in Women's and Newborn Services. During this time, she has participated in many research projects.
Dr Diane Payton	2011	MBBS, FRCPA	Anatomical Pathologist, Pathology Queensland	Diane Payton performs and supervises perinatal, neonatal, and paediatric autopsies for public and private patients throughout Queensland. I was the previous Chair of the Paediatric Advisory Committee for the RCPA and an involved in the discussion with the Federal Government re-funding and staffing for perinatal and placental pathology.
Dr Richard Mausling	2018	MBChB, FRACP	Staff Specialist, Neonatology, Mater Health Services	Richard is South African trained doctor who completed my paediatric and neonatal training in New Zealand and Australia. He received a FRACP from the Royal Australasian College of Physicians in 2014 and has been employed as a Staff Specialist Neonatologist at the Mater Mothers Hospital since 2016. He works in a combined perinatal and cardiac/surgical unit and as such we see a very varied clinical presentation of patients. He works very closely with our colleagues at the Queensland Children's Hospital, which is co-located on the same campus as the Mater Mothers Hospital, to provide the best care for the patient population.

Dr Christoph Lehner	2019	MD, PhD, FRANZCOG	Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Chris is a Maternal Fetal Medicine Specialist with 20 years of obstetric experience in Germany and Australia. Currently he is a Consultant Obstetrician and Fellow in Maternal Fetal Medicine at the Royal Brisbane and Women's Hospital. His clinical work involves management of complex high-risk pregnancies with a special interest in maternal cardiac disease, obstetric ultrasound, and prevention of preterm birth. He is a Senior Lecturer at the University of Queensland (UQ) and member of the Board of Examiners in Obstetrics and Gynaecology at the UQ School of Medicine. His current research focuses on pathophysiology and prevention of preterm birth and stillbirth education.
Dr Admire Matsika	2015	MBChB, FRCPA, MBA, AFRACMA, AAICD	Director of Anatomical Pathology and Senior Anatomical Pathologist, Mater Health	Admire is only one of a handful of Perinatal pathologists in Queensland performing autopsies for public and private hospitals. He is an active researcher in the perinatal and genitourinary tumors space.
Imogen Kettle	2018	RN/RM,BN,Mast Ed. (Research)	Clinical Midwife Consultant- Maternity Mortality Projects, Patient Safety and Quality, Clinical Excellence Queensland.	Imogen Kettle is a Clinical Midwife Consultant with expertise in perinatal case review, pregnancy care, research, audit, and education. She coordinates projects analysing serious adverse maternal and perinatal incidents and supports maternity services with their own incident reviews. Imogen has worked in research and has a background in tertiary and health service education, advancing the learning of student midwives. She has over 30 years of midwifery experience which included practicing in an Outreach Community pregnancy care clinic and teaching childbirth and parenting education.
Dr Janet Sharpe	2019	B. Phty, MBBS (Hons), DCH, FRACP, GCert QS (Health and Safety)	Senior Medical Officer, Neonatology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Dr Sharpe is a Consultant Neonatologist with a particular interest, experience and postgraduate qualifications in Safety and Quality. Dr Sharpe has worked in neonatology across both public and private sectors, and in tertiary and peripheral units, as well as having a background in the paediatric disability sector, and continues to strive for the best outcomes for neonates, both in her care and in the community overall.
Dr Poliana De Barros Medeiros	2020	MBBs Brazil	Staff Specialist, Neonatology, Sunshine Coast Hospital and Health Service; NHMRC Centre of Research Excellence in Stillbirth (Stillbirth CRE)	Poli is a neonatologist currently undertaking a PhD focusing on perinatal mortality audits and classification to drive practice change in perinatal death and "neonatal near miss".

Kaylene Matthews	2023	BNu, Dip Mid	Acting Midwifery Unit Manager of Midwifery Group Practice, Sunshine Coast Hospital and Health Service	Kaylene is a Registered Nurse / Clinical Midwife, specialising in emergency nursing and antenatal care. Recently acting as Midwife Unit Manager for Midwifery Group Practice at the SCHHS (2023-2024) – Qld's Exemplar site for Publicly Funded Homebirth
Cherie Boniface	2021	GrdCert Nu GrdCert Midwifery GrdCert Neonatal Nu	Clinical Midwifery Consultant, Maternal Fetal Medicine Townsville University Hospital, Townsville Hospital and Health Service	Cherie is a registered nurse/midwife with extensive Neonatal nursing experience and currently holds a position at Townsville University Hospital as the Clinical Midwifery Consultant for Maternal Fetal Medicine since May 2013.During this period she has been preparing and classifying case reviews for our Perinatal Mortality Meetings at the Townsville University Hospital. As part of this process, we investigate contributing factors related to each case and determine if there are avoidable or preventable factors and recommend and implement changes and improve outcomes for mothers and babies in our region. Cherie is an IMPROVE educator and her special interest area is perinatal mortality classification. Cherie provides insight into maternity care for the Northern Region of Queensland. Cherie is a neonatal nurse and is the Clinical Midwifery Consultant in NQ Maternal Fetal Medicine. She has been working in this area for the last 13 years. Cherie has previously worked a research midwife at the Townsville Hospital and as a Clinical Nurse in the Neonatal Unit.
Tara Denaro	2023	B Nu, Dip- Mid Cert- Nu Peads	Clinical Nurse Consultant, Strong Start to Life, Aboriginal and Torres Strait Islander Leadership Team, Metro North Hospital and Health Service	Tara is a First Nations women working in maternity across Metro North. She is a member of · the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, a member of QNMU Aboriginal and Torres Strait Islander Reference Group and a Member of Australian College of Midwives.
Courtney Hala	2023	BSocSc, BMid, GDipHealthProm	Statewide Aboriginal and Torres Strait Islander Perinatal and Infant Mental Health Coordinator, Child and Youth Mental Health Service, Children's Health Queensland	Courtney is a registered midwife and a strong, proud Aboriginal Wiradjuri woman who actively participates in her local (Brisbane North) Aboriginal community. Her role as a Clinical Midwife Consultant with Children's Health Queensland is a testament to her dedication to Aboriginal and Torres Strait Islander health, where she focuses on supporting families with cultural sensitivity and emotional intelligence. With over three years of coordinating perinatal and infant mental health services statewide, she has honed her expertise in workshop facilitation and communication, ensuring that families receive culturally competent care.

Dr Jane Maher	2024	MBBS FRANZCOG JP(Qual)	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast university Hospital, Sunshine Coast Hospital and Health Service	Jane Maher is a SMO and current deputy director in the Department of Obstetrics and Gynaecology at the Sunshine Coast University Hospital. Dr Maher has an interest in high-risk obstetrics and works closely with the Maternal Fetal Medicine department. She currently holds the portfolio for clinical incident review at the SCHHS O&G department and sat on the committee as Obstetric lead for development of the Publicly Funded Home Birth program at SCUH – the first in Queensland.
Nicole Payne	2024	BNursing/BMidiwfery, Master of Midwifery.	Substantive position: Nurse Navigator ToP Metro North	Experienced Nurse/Midwife, recent position relating to the care of women experiencing a termination of pregnancy.
Esther Taylor	2024	B Hlth Sci Health Information Management	Principal Data Collection Officer, Statistical Collections and Integration Unit, Statistical Services Branch, Healthcare Purchasing and System Performance Division	Esther Taylor is the Principal Data Collection Officer of the Queensland Perinatal Data Collection (QPDC), Queensland Perinatal Mortality Data Collection (QPMDC), Queensland Maternal Mortality Data Collection (QMMDC), Queensland Hospital Admitted Patient Data Collection (QHAPDC) as well as the Queensland Birth registration Data Collection (QBRDC) and Queensland Death Registration Data Collections (QDRDC). Her background is in providing trusted statistical data and information, meta data standards, statistical reporting, and analytics to meet official reporting requirements to enable funding recoupment and to create an evidence base for informed decisions that improve health and health service delivery.
Kate Whelan	2024	B Nur	Principal Data Collections Officer - QHAPDC and QPDC, Statistical Collections and Integration Unit, Statistical Services Branch, Queensland Health	Kate has experience and awareness of all clinical incident management processes (operational and clinical challenges in undertaking SAC 1 reviews) specifically with a focus on midwifery, neonates, and paediatrics. Strong understanding of Governance and Patient Safety.
Emma Porter	2024	BN, GradDipMid, DipCouns	Clinical Consultant – Research, NHMRC Centre of Research Excellence in Stillbirth, Clinical Midwifery Consultant – Service Lead, Mater Mothers Perinatal Loss Service, South Brisbane	Emma Porter is a Clinical Midwifery Consultant with expertise in perinatal care, bereavement support, and research. Dedicated to improving outcomes for families experiencing pregnancy loss and stillbirth, she co-leads the Perinatal Mortality Review Committee at Mater Mothers, South Brisbane. Currently, Emma is practicing as a Clinical Consultant in Research at Stillbirth CRE, where she plays a key role in advancing best practices in perinatal loss care and education.

Abi Pycroft	2025	BPsychSc, MSW	Perinatal Loss Administration Assistant, Pathology Queensland, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Abi Pycroft is a Perinatal Loss Administration Assistant with Pathology Queensland. Her background and experience include working as a Maternity and Neonatology Social Worker at the Royal Brisbane and Women's Hospital, providing psychosocial and emotional support to diverse populations, including those experiencing, or who have experienced, perinatal loss. Abi has gained valuable insight and experience into how the loss of a baby can impact families and has supported numerous mothers and fathers by providing bereavement support, grief and loss counselling and psychoeducation as well as practical and logistical support.
Krissy Wallace	2025	BSci-ForSc, GDipForenSc	Perinatal Loss Administration Assistant, Pathology Queensland, Sunshine Coast University Hospital, Sunshine Coast Hospital and Health Service	Krissy Wallace is a Perinatal Loss Administration Assistant with Pathology Queensland. Her background includes working as a Mortuary Technician at Sunshine Coast University Hospital, where she was involved in perinatal autopsies. She has assisted across multiple mortuaries throughout Queensland, gaining valuable insight into the various processes and practices within the perinatal space. With a strong passion for streamlining procedures and fostering successful collaborations, she is committed to enhancing the quality of care and support for families experiencing perinatal loss.
Tammy Doyle	2023	BNur	Clinical Nurse Consultant Safety Improvement Support Officer/Patient Safety Officer Sunshine Coast Hospital and Health Service	Tammy actively leads and contributes to activities that support safe, patient focused care, and positively foster a supportive safety culture. Her long-term goal is to invest and transition into implementing and strengthening the quality improvement cycle that focuses on priority areas of transitioning evidence-based practices into safer care and promoting safety cultures within multidisciplinary teams. SISO WCS SCHHS role includes: •Coordination of incident reviews (RCA, HEAPS, Clinical Reviews) •Coordination and participation of Open Disclosure •Monitoring, coordination, and implementation of incident review recommendations •Development of individual, division/ service line/ facility and organization wide clinical incident report trending reports. •Provide technical advice and leadership through the co-ordination of NSQHS Standards activities. •Review reports (internal and external to the health service) and monitor progress of safety and quality performance
Elly Marie	2023		Consumer Representative	Consumer Representative
Katie Allan	2024		Consumer Voice – Postpartum Doula	Consumer Voice – Postpartum Doula

Congenital Anomaly subcommittee	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Dr Renuka Sekar (CASC Chair)	2010	MBBS, Dip. Gynecology and Obstetrics, FRANZCOG, CMFM	Clinical Lead, Maternal and Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Renuka Sekar is Senior Staff specialist Obstetrics and Subspecialist Clinical Lead Maternal and Fetal Medicine. Senior Lecturer at UQ since 2009. Vast experience in managing complex pregnancies, teaching, research and training. Actively involved with Queensland Guidelines especially aneuploidy and genetic screening in pregnancy.
Professor Timothy Donovan	2011	MBBS, FRACP, Masters Public Health	Neonatal Medicine and Consultant Neonatology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Tim has served on the steering committee since February 2014 and have been Chair of the Congenital Anomalies Subcommittee from 2019 to 2024. Tim provides insight into the perinatal care of newborns from a tertiary neonatal facility as well as contributing significantly to regional assessments of perinatal outcomes in Queensland.
Dr Sarah Tozer	2021	BSci-Med Sci, PhD	QMPQC Co-ordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland	Dr Sarah Tozer is the principal project officer responsible for coordinating all functions and activities for the QMPQC. Her background is in molecular, diagnostic, translation research in area of infectious diseases, particularly paediatric infectious diseases. Sarah has worked across multiple services, with numerous stakeholders from private enterprise, universities, industry, and public healthcare.
Dr Diane Payton	2011	MBBS, FRCPA	Anatomical Pathologist, Pathology Queensland	"Diane is a perinatal anatomical pathologist at Queensland Pathology, Herston. She has special interests in the unexplained late gestation/term intra uterine death of normal appearing well grown infants. She is currently Chair of the Paediatric Advisory Committee for RCPA and in this position attended and presented at the Senate enquiry into Stillbirth and advocated for detailed high-quality autopsies performed by specialised perinatal pathologists. "
Dr Nikki Whelan	2010	MBBS, FRANZCOG	Private Consultant Obstetrician & Gynaecologist	Dr Whelan is a member of SOMANZ, ISOM, NASOM, ISSHP, ADIPS, AND IADPSG, and actively participates in their regular meetings and congresses. Since 2002 Nikki Whelan has been a member of the Queensland Maternal and Perinatal Committee. I am a member of the Maternal Mortality Sub-Committee and currently chair this meeting and am a member of the Perinatal Mortality Sub-Committee.

Cherie Boniface	2023	GrdCert Nu GrdCert Midwifery GrdCert Neonatal Nu	Clinical Midwifery Consultant, Maternal Fetal Medicine Townsville University Hospital, Townsville Hospital and Health Service	Cherie is a neonatal nurse and is the Clinical Midwifery Consultant in NQ Maternal Fetal Medicine. She has been working in this area for the last 13 years. Cherie has previously worked a research midwife at the Townsville Hospital and as a Clinical Nurse in the Neonatal Unit.
Dr Jane Maher	2022	MBBS FRANZCOG JP(Qual)	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast university Hospital, Sunshine Coast Hospital and Health Service	Jane Maher is a SMO and current deputy director in the Department of Obstetrics and Gynaecology at the Sunshine Coast University Hospital. Dr Maher has an interest in high-risk obstetrics and works closely with the Maternal Fetal Medicine department. She currently holds the portfolio for clinical incident review at the SCHHS O&G department and sat on the committee as Obstetric lead for development of the Publicly Funded Home Birth program at SCUH – the first in Queensland.
Pauline McGrath	2016	MNurs Lead, FHGSA	Principal Genetic Counsellor Children's Health Queensland	Pauline is a Human Genetics Society of Australasia registered Genetic Counsellor. She has been the genetic counselling clinical lead for prenatal and fetal medicine genetic counselling services for Queensland until 2024 when she was appointed Principal Genetic Counsellor CHQ to establish in house genetic counselling for QCH. In 2013 she was awarded a Churchill Fellowship to explore the provision of counselling support for women accessing emerging pre-natal testing technologies. She has also been involved in the development of national guidelines and Queensland Clinical guidelines for screening and diagnosis in pregnancy
Dr Susan Ireland	2024	MB ChB, FRACP, PhD	Senior Medical Officer, Townsville University Hospital	Susan Ireland is a neonatologist working at the Townsville University Hospital since 2006. Prior to this she was employed in the UK NHS. She has been a member of the QCPC Infant mortality group since its inception and has participated in multiple statewide neonatal guidelines. Her area of interest includes the care of periviable babies, and staff and parental perspectives and involvement in decision making.
Kate McFarlane	2024	BNUR,BN ProfHons (NICU) MCN (NICU)	Clinical Nurse, Special Care Nursery, Hervey Bay Hospital	Kate McFarlane is a senior clinical nurse with both tertiary and regional experience in neonatal nursing since 2011 in QLD. She regularly contributes to the development of statewide clinical guidelines and forum regarding neonatal nursing education.
Tim Cudmore	2023		Consumer Representative	Tim has lived experiences of a baby born with a congenital anomaly.
Ahlia Griffiths	2023		Consumer Representative	Consumer Representative

Congenital Syphilis Working Group	Year Commenced	Qualification	Position	Summary of experience relevant to QMPQC
Professor Leonie Callaway (Co Chair)	2018	MBBS (Hons I) FRACP PhD GCE Lead GAICD	Clinical Lead, Maternal and Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Renuka Sekar is Senior Staff specialist Obstetrics and Subspecialist Clinical Lead Maternal and Fetal Medicine. Senior Lecturer at UQ since 2009. Vast experience in managing complex pregnancies, teaching, research and training. Actively involved with Queensland Guidelines especially aneuploidy and genetic screening in pregnancy.
Professor Clare Nourse	2021	AM BA MB BCH BAO DCH MRCPI FRACP MD	Paediatric Infection Specialist, Infection Management and Prevention Services, Children's Health Queensland, Faculty of Medicine, University of Queensland	Paediatric Infection Specialist, with experience both clinical and research in Congenital Syphilis. Professor Clare Nourse is a Paediatric Infection Specialist at Queensland Children's Hospital in Brisbane and Professor in the School of Clinical Medicine at the University of Queensland. She qualified in medicine from Trinity College Dublin and trained in Dublin, Melbourne and Brisbane.
Dr Sumi Britton	2021	BSc, MBBS (Hons), FRACP, PhD	Staff Specialist, Infectious Diseases, Royal Brisbane and Women's Hospital	Dr Sumi Britton is an adult infectious diseases physician with a subspeciality interest in infections in pregnancy specifically HIV and syphilis and a research background in infectious diseases diagnostics.
Catherine Spucches	2018	B Science (Public Health), B Science (Hons) (Health Promotion)	Principal Public Health Officer (STI Team Lead), BBV/STI Unit, Communicable Diseases Branch, QPHaSS	Catherine Spucches is a public health professional who has been working since 2006 in statewide public health roles in the areas of population screening and communicable diseases prevention. She currently oversees the STI portfolio within the Department's BBVSTI Unit and is the author and overseer of the Queensland Syphilis Action Plan 2023-2028. Catherine has been actively involved in the Queensland syphilis response since 2017.
Dr Renuka Sekar	2018	Clinical Lead, Maternal and Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Clinical Lead, Maternal and Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service	Renuka Sekar is Senior Staff specialist Obstetrics and Subspecialist Clinical Lead Maternal and Fetal Medicine. Senior Lecturer at UQ since 2009. Vast experience in managing complex pregnancies, teaching, research and training. Actively involved with Queensland Guidelines especially aneuploidy and genetic screening in pregnancy.

Alison Thompson	2018	B App Science, Grad Dip Health Promotion, Grad Cert Management.	Director BBV/STI Unit, Communicable Diseases Branch, QPHaSS	Ms. Thompson is a public health practitioner and has been Director, BBV/STI Unit in the Department of Health since 2016. She is responsible for leading the system-wide response to the prevention and management of BBV/STIs in Queensland with a priority focus on syphilis. She oversees the development and implementation of Departmental policies, programs, strategies relating to the public health response to BBV/STIs. Alison is the Queensland Health representative on the national Blood Borne Viruses and Sexually Transmissible Infections Standing Committee to AHPPC.
Dr Diane Rowling	2018	MBBS FAChSHM FAFPHM	Substantive Position Public Health Physician Sexual Health Metro North Public Health Unit Rosemount Campus Clinical lead for QSSS South. Currently on secondment Senior Medical Officer Sexual Health and HIV Service Metro North.	Dr Diane Rowling is a Sexual Health and Public Health Physician. She was Clinical lead for the establishment of the Qld Syphilis Register (later to become QSSS in 2014) based at the Sexual Health and HIV Service Metro North in 2001. She was a Senior Staff Specialist at this specialised clinical service providing sexual health and HIV care for 20 years prior to moving to a public health role with syphilis surveillance. She is a former Medical Director of Family Planning Qld and member of the Qld Sexual Health Ministerial Advisory Committee 2022-2025.
Emma Sanguineti	2021	MClinEpi BHlthSci(Public Hlth)	Advanced Epidemiologist, Epidemiology and Research Unit, Public Health Intelligence Branch, Queensland Public Health and Scientific Services, Department of Health	Emma Sanguineti is an Advanced Epidemiologist responsible for supporting state-wide communicable disease epidemiology and surveillance of notifiable sexually transmissible infections.
Dr Diane Payton	2018	MBBS, FRCPA	Anatomical Pathologist, Pathology Queensland	Diane is a perinatal anatomical pathologist at Queensland Pathology, Herston. She has special interests in the unexplained late gestation/term intra uterine death of normal appearing well grown infants. She is currently Chair of the Paediatric Advisory Committee for RCPA and in this position attended and presented at the Senate enquiry into Stillbirth and advocated for detailed high-quality autopsies performed by specialised perinatal pathologists.
Dr Annie Preston-Thomas	(2018) 2025	MBChB, MPH, DipG&O, FRACGP, FAFPHM	Public Health Medical Officer, Tropical Public Health Services Cairns, Cairns and Hinterland Hospital and Health Service	Annie is a Public Health Physician with 30 years of medical experience, including 13 years of public health experience and 13+ years working for Aboriginal Community Controlled Health Services. Annie successfully advocated for resources (North Qld STI Action Plan, North Qld HIV response), led regional responses, and contributed to state and national policies and guidelines. Work with QSSS since 2013. Contributed to Qld Syphilis in Pregnancy Guideline. Participated in original QMPQC review of congenital syphilis cases.

Dr Sarah Tozer	2021	BSci-Med Sci, PhD	QMPQC Co-ordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland	Dr Sarah Tozer is the principal project officer responsible for coordinating all functions and activities for the QMPQC. Her background is in molecular, diagnostic, translation research in area of infectious diseases, particularly paediatric infectious diseases. Sarah has worked across multiple services, with numerous stakeholders from private enterprise, universities, industry, and public healthcare.
Dr Candice Holland	2025	MBBS, MPHTM, FRACP, FAFPHM	Clinical lead – Queensland Syphilis Surveillance Service (South)	Dr Candice Holland is an infectious diseases and public health physician working at Ipswich Hospital and QSSS-South within MNPHU. She has been clinical lead for QSSS-South since March 2024 and has a clinical caseload of adults with syphilis including management of cases of syphilis in pregnancy and for persons who are incarcerated. She is a senior lecturer with University of Queensland and board member for the Australasian Society of Infectious Diseases.
Paula Hale	2025	RN BA (Hons), BSC (Hons) Grad Dip	RN BA (Hons), BSC (Hons) Grad Dip	Nurse Navigator – Sexual Health, Metro North Public Health Unit
Elena Mcleish	2025	RN, Bachelor of Nursing, Post Grad Cert in Public Health	Clinical Nurse Consultant/PHN – Queensland Syphilis Surveillance Service, Metro North Public Health Unit	Elena Mcleish is Registered Nurse, with extensive experience in sexual health and HIV. Over the past 7 years more prominently regarding syphilis infections, including enhanced surveillance, management, and educational support.

Former committee members

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

Member	Year Commenced	Year Resigned	Membership on	Position
Dr Helen Pedgrift	2022	2023	CSWG	A/Public Health Medical Officer, Sexual Health, Tropical Public Health Service Cairns and Hinterland Hospital and Health Service
Professor Paul Colditz (Co-Chair)	2018	2023	CSWG	Neonatologist, Director, Perinatal Research Centre and Head of School of Clinical Medicine, The University of Queensland,
Professor Vicki Flenady	2018	2022	CSWG PMSC	Director; Co-lead Risk Factors; Co-lead Implementation; Centre of Research Excellence in Stillbirth - Stillbirth CRE
Dr Jacqueline Mein	2018	2020	CSWG	A/Public Health Medical Officer, Sexual Health, Tropical Public Health Service Cairns and Hinterland Hospital and Health Service
Dr Mandy Seel (Co-Chair)	2018	2020	CSWG	Public Health Physician – Sexual Health, Public Health Unit, Metro North Hospital and Health Service.
Marce Green	2018	2023	QMPQC	Consumer Representative
Dr Rebecca Jenkinson	2012	2023	QMPQC	Consumer Representative
Catherine Alexander	2021	2023	QMPQC	Clinical Midwife Consultant, Caboolture Hospital, Metro North Hospital and Health Service
Professor Julie McEniery	2012	2023	QMPQC	ex-officio as Chair, Queensland Paediatric Quality Council
Dr Trisha Johnston	2012	2024	QMPQC PMSC CASC	Director, Statistical Analysis and Linkage Unit, Statistical Services Branch, Queensland Health
Dr Elisabeth Hoehn	2016	2024	QMPQC	Medical Director, Queensland Centre for Perinatal and Infant Mental Health, Child and Youth Mental Health Service, Children's Health Queensland
Karen McGill	2023	2024	QMPQC PMSC CASC	Director Statistical Analysis & Linkage Statistical analyst Stats Analysis Unit, Statistical Services Branch
Mile Utz	2023	2024	QMPQC PMSC CASC	Senior Analyst, Statistical Analysis and Linkage Unit, Statistical Services Branch
Dr Di Milnes	2023	2024	QMPQC CASC	Clinical Geneticist, Genetic Health Queensland

Melleesa Cowie	2024	2024	QMPQC	ex-officio as Director Nursing Clinical Governance, Patient Safety and Quality, Clinical Excellence Queensland,
Sherry Holzapfel,	2020	2021	QMPQC	Director, Aboriginal and Torres Strait Islander Health Unit, Metro North Hospital and Health Service
Dr Fiona Britten	2020	2021	QMPQC	Endocrinologist and Obstetric Physician, Metro North Hospital and Health Service
Dr Shahida Rehman	2020	2021	QMPQC	Specialist, Obstetrics and Gynaecology, Metro North Hospital and Health Service
Dr Benjamin Bopp	2020	2021	QMPQC	Director of Obstetrics and Gynaecology, Gold Coast Hospital and Health Service
Dr Jessica Gaughan	2020	2021	QMPQC	Senior Medical Officer, Obstetrics and Gynaecology, Central Queensland Hospital and Health Service
Dr Jocelyn Toohill	2019	2024	QMPQC	ex-officio as Director of Midwifery, Office of The Chief Midwife Officer
Tionie Newth	2021	2023	PMSC	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast Hospital and Health Service
Azure Rigney	2022	2023	PMSC	Consumer Representative
Leah Hardiman	2022	2023	PMSC	Consumer Representative
Dr Cathrine Kilgour	2021	2023	PMSC	Lecturer (Teaching and Research) School of Nursing, Midwifery and Social Work, The University of Queensland and Midwife/Registered Nurse Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr Jessica Sexton	2023	2024	PMSC	Epidemiologist, Senior Research Fellow Data to Drive Change Program Lead, NHMRC Centre of Research Excellence in Stillbirth Mater Research Institute
Dr Jane Maher	2022	2024	MMSC	Senior Medical Officer, Obstetrics and Gynaecology, Sunshine Coast university Hospital, Sunshine Coast Hospital and Health Service
Dr Bruce Maybloom	2022	2024	MMSC	Private General Practitioner and Perinatal Epidemiologist
Dr John Clift	2020	2023	MMSC	Senior Medical Officer, Anaesthesia, Rockhampton Hospital, Central Queensland Hospital and Health Service
Dr Thangeswaran Rudra	2018	2023	MMSC	Senior Consultant, Obstetrics and Gynaecology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr Lee Minuzzo	2022	2023	MMSC	Senior Consultant Obstetrician, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr William Parsonage	2011	2023	MMSC	Staff Specialist, Cardiology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr Johanna Laporte (Chair)	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Maternal Fetal Medicine Specialist, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service

Deborah Birthisel	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Clinical Midwife, Birth Suite, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Professor Timothy Donovan	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Neonatal Medicine and Consultant Neonatology, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr Christoph Lehner	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Registrar, Maternal Fetal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
Dr Admire Matsika	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Specialist Consultant Anatomical Pathologist, Mater Pathology
Teresa Walsh	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Director and Midwife, New Life Midwifery Pty Ltd
Leah Hardiman	2020	2023	Perinatal Mortality Contributing Factors Case Review Panel	Consumer representative
Dr Nikki Whelan	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Private Consultant Obstetrician & Gynaecologist
Imogen Kettle	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Clinical Midwife Consultant- Perinatal Mortality Projects, Patient Safety and Quality, Clinical Excellence Queensland.
Dr Janet Sharpe	2018	2023	Perinatal Mortality Contributing Factors Case Review Panel	Staff Specialist Neonatologist, Sunshine Coast Hospital and Health Service

Dr Poliana De Barros Medeiros	2023	2023	Perinatal Mortality Contributing Factors Case Review Panel	Neonatologist, NHMRC Centre of Research Excellence in Stillbirth (Stillbirth CRE) Mater Health Services
Dr Sarah Tozer	2022	2023	Perinatal Mortality Contributing Factors Case Review Panel	QMPQC, the Council Co-Ordinator and Secretariat, Patient Safety and Quality, Clinical Excellence Queensland

Privacy policy - December 2023

POLICY STATEMENT: Members of the Queensland Maternal and Perinatal Quality Council (QMPQC) and those staff working on matters assigned by the QMPQC must maintain the confidentiality of information they acquire or come across during their work with in Council and the subcommittees.

OUTCOME STANDARD: Patient information acquired during work undertaken by or on behalf of the QMPQC, is managed and maintained in a totally confidential manner and is only discussed between members of the Council in accordance with Hospital and Health Boards Act 2011, Sections 81-90 and this Policy.

EVALUATION METHOD: QMPQC The Council to review the specific breaches, if any, at bi-monthly meetings.

Under the privacy policy, all QMPQC members are required to familiarise themselves with the current ToR and the Privacy policy to ensure all patient information/data provided to the QMPQC is maintained in a totally confidential manner and not divulged to any other person. To ensure QMPQC members and those staff who are working at the direction of QMPQC, do so in accord with this policy. To ensure QMPQC complies with Hospital and Health Boards Act 2011, Sections 81-90.

This Policy encompasses the following:

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

All members and those staff who are working under the auspice of the Council must sign the Queensland Health QMPQC Confidentiality Agreement.