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27 October 2016

Mr Iain West
Deputy State Coroner
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3006

Dear Mr West

Your Reference COR2011002565

Re Coroners Recommendations after the Death of Kelly Maree Richards

Recommendation:

It is recommended that the Royal Australasian College of Surgeons Institute Guidelines addressing the need for communication between the operating surgeon from the referring Hospital and the surgeon at the receiving hospital in circumstances requiring urgent transfer, notwithstanding the presence of the retrieval doctors.

This matter of clinical handover in general, and particularly where vital clinical matters are involved, has been brought to the attention of surgeons by the Royal Australasian College of Surgeons (RACS) intermittently. The issue of clinical handover within a hospital and between hospitals has been highlighted in articles in Surgical News (monthly RACS publication) to all surgeons, trainees and International Medical Graduates.

Also there have been publications in the "Lessons Learnt" from the Audits of Surgical Mortality from time to time where this issue may have affected a death. This Audit process examines every in-hospital death where the patient is admitted under a surgeon.

However RACS does not have a formal Policy or Position Paper on handover especially in relation to emergency situations from a regional or other hospital to a tertiary centre; nor where intraoperative catastrophe has occurred.

It is accepted and agreed that this handover should occur between the operating/treating surgeon from the first hospital to the receiving consulting surgeon at the Tertiary Hospital. This information should not be diluted by other layers of communication nor be left to the retrieval service.

RACS is in the process of developing such a Position paper, in response to your recommendation, in addition mention of this principle will be highlighted in a new segment of Surgical News to be called "Coroners Corner" where issues brought to our attention by Coroners from various jurisdictions can be highlighted.

Recommendation:

That the Royal Australasian College of Surgeons consider mandatory and regular continuing professional development with theoretical and practical components for surgeons performing laparoscopic procedures.

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It should be noted that the RACS does have a robust Continuing Professional Development (CPD) process which covers technical and non-technical skills. At the Annual Scientific Congress (ASC) there are "How I Do It" master classes and sessions related to various topics and surgeons are encouraged to attend for procedural and theoretical instruction. It is also noted that most General Surgeons now perform laparoscopic procedures and the injury rate to intra-abdominal organs and structures is very low and death relating to such injuries is incredibly low.

It is not possible or practical to mandate "practical courses for all surgeons who perform laparoscopic procedures" to manage an issue that is incredibly rare.

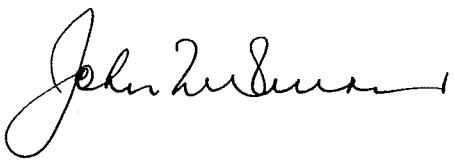
In a Hospital setting, audit of surgical practice should identify those whose practice is leading to problems and focused remediation can be arranged.

By implication the Coroner's findings suggest that poor technique is related to age. RACS refutes this implication; as young and more senior surgeons both may experience complications and surgical audit in-Hospital unit morbidity and mortality activities should bring this to light.

It should be noted that as part of compulsory CPD peer review audit is mandatory as is participation in the Audit of Surgical Mortality in each state. Both of these activities allow for self-reflection and opportunities for remediation if a problem (of any type) is identified.

This recommendation is not able to be practically undertaken nor is it necessary, in the opinion of the RACS.

Yours sincerely



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