The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Excellence in Women's Health

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Coroner Simon McGregor
Coroners Court of Victoria
cpuresponses@coronerscourt.vic.gov.au

28 November 2019

Dear Coroner McGregor,

Re: Investigation into the death of Finn Moser
(Court ref: COR 2017 000191)

Thank you for your letter of 4 November 2019 and the opportunity to respond to recommendations made in response to the death of Baby Finn Moser. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) are committed to ensuring that pregnancy and birth are as safe as possible, and the College welcomes the opportunity to contribute.

Having reviewed the Finding into the death without inquest, acknowledgement has been made that there has been an increasing number of cases of fetal injury at caesarean section reported in recent years. I can advise that in response to your investigation, the coronial findings and expert reports have been brought to the attention of the RANZCOG Women's Health Committee, Council and Board.

The Coroner's recommendation 2 will be implemented.

The College has already commenced a review of their guidance and education resources covering the issues outlined in this recommendation. Unfortunately, the College is unable to mandate a specific obstetric emergency scenario be implemented by hospitals. Individual hospitals can choose to include simulated training for *any* obstetric emergency they identify as relevant to their service. This may or may not include disimpaction of the fetal head at caesarean section and may not include theatre teams in maternity scenario-based training. The College has commenced the development of scenarios in RANZCOG obstetric emergency education, which include techniques to be adopted for the safe delivery of a baby where the head is deeply impacted in the pelvis. The College will communicate to members and education facilitators that a greater emphasis on this scenario should be incorporated into obstetric emergency training.

The Coroner's recommendation 4a will be implemented.

The Women's Health Committee reviews and updates statements and guidelines concerning various aspects of maternal and perinatal care and as recommended have considered these findings in the context of a review of the College statement *Delivery of the fetus at caesarean section (C-Obs 37).* As recommended, the College statement has been amended to include the following three new recommendations:

> Recommendation 2 *"Where an impacted fetal head is suspected, the most senior obstetric doctor present should perform a vaginal examination immediately before commencing a caesarean section to exclude the possibility of further descent of the presenting part such that vaginal delivery would be more easily accomplished."*
>
> Recommendation 3 *"Clinicians experienced in caesarean sections and trained in neonatal resuscitation should be in attendance or readily available where a technically difficult delivery is anticipated."*
>
> *Recommendation 5 "Consideration should be given to incorporating difficult caesarean section scenarios into obstetric emergency training with both maternity and theatre teams including disimpaction of the fetal head at caesarean section."*

Unfortunately, the Coroner's recommendation 4b is unable to be implemented.
The College has never recommended the implementation of a mandatory surgical safety 'time-out' checklist which specified the need for a vaginal examination and identification of the roles and responsibilities of all staff. This recommendation was presented to the College by Coroner English as a proposed recommendation following the investigation into the death of Baby Lucia Grace Sefton. The Committee does not support the addition to the time out list due to the infrequency of this condition and the utilisation of standard lists in hospitals. Additionally, the Committee felt that this discussion should not take place in the presence of the woman or her partner, which is the practice for timeout at caesarean section, as this will increase their levels of anxiety.

The Coroner's recommendation 2d has already been implemented.
The recommendation that continuous fetal monitoring, particularly in theatre and up until the time of caesarean has been incorporated as a Good Practice Point in the RANZCOG *Intrapartum Fetal Surveillance Clinical Guideline – 4th edition* which was approved for publication in November 2019. This recommendation has also been included into the RANZCOG Fetal Surveillance Education Program.

I wish to thank you for the opportunity to provide feedback on these recommendations.
Please do not hesitate to contact Ms Jacqueline Maloney, Senior Women's Health Co-ordinator / Guideline Developer, at jmaloney@ranzcog.edu.au or phone (03) 94122913 should you have any queries or concerns.

Yours sincerely,

Prof Yee Leung
Chair, Women's Health Committee
Royal Australian and New Zealand College of Obstetricians and Gynaecologists