18 November 2022

Coroner Levasque Peterson
Coroners Court of Victoria
cpuresponses@coronerscourt.vic.gov.au

Dear Coroner Peterson,

Re: Finding into death without inquest – Ruth Ann McKenna

We thank the Court for providing RANZCOG with a copy of Coroner Peterson's 'Finding into the death of Ruth McKenna'. We are grateful for the opportunity to contribute to the lessons learnt from this tragic outcome and to systems changes to reduce the risk of similar events in the future.

The Coroner made the following recommendation relevant to RANZCOG:
'I recommend that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists liaise with the Department of Health to explore the possibility and feasibility of developing a laparoscopic surgery database within Victoria to enhance quality and accountability in laparoscopic gynaecological surgery. Such a database could enable health authorities to access live outcome data, provide feedback to clinicians, target training, and make recommendations to clinicians and services regarding service capability.'

RANZCOGs Women's Health Committee and members of the Endoscopic Surgical Advisory Committee reviewed the recommendation. The members support implementation of the Coroner's recommendation. We note the following important considerations:

- Victoria has an existing system for reporting surgical mortality. The Victorian Audit of Surgical Mortality (VASM) is a collaboration between the Victorian Government's Department of Health, Safer Care Victoria, and the Royal Australasian College of Surgeons (RACS). RANZCOG is represented on the VASM management committee. The audit process is initiated by notification of the death of a patient while under surgical care. At the end of the process, feedback is provided to the clinician concerned. Each state and territory has a similar body and all are reviewed by The Australian and New Zealand Audit of Surgical Mortality (ANZASM). RANZCOG is represented on the ANZASM steering committee.

- A tool for capturing adverse surgical events is required. Surgical morbidity data are collected by hospitals as part of their accreditation requirements, but these data may not be completely accurate or widely accessible. Members agreed that such a tool should not be limited to gynaecological surgery, nor laparoscopic procedures, but include all other areas of surgery. Ideally this would be a national database, designed by and led by clinicians, which captures surgical outcomes that could be analysed in real time to inform practice and maximise patient safety. This is a project larger than RANZCOG can individually progress, but one we would be keen to engage with.

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- RANZCOG trains and accredits doctors in the specialties of obstetrics and gynaecology and administers the ongoing Continuing Professional Development (CPD) of its members. RANZCOG however, is not responsible for credentialing and performance assessment of individual clinicians, and this remains the responsibility of their local institutions.

To this end, in line with the Coroner's recommendation, RANZCOG supports the concept of developing a surgical audit program and will liaise with the Victorian Government's Department of Health to establish the feasibility of such a program. The establishment of a national surgical audit program (which would be preferable) may be beyond the scope of such a state-based collaboration and alternatives may need to be considered. RANZCOG commits to providing gynaecological expertise to a surgical audit program should it arise.

Yours sincerely,

Dr Benjamin Bopp
President