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

15 July 2021

Coroner Jacqui Hawkins
Coroners Court of Victoria
cpuresponses@coronerscourt.vic.gov.au

Dear Coroner Hawkins,

Re: Investigation into the death of Cai-Wheeler Trow | Court reference: COR 2017 005946

Thank you for your letter of 31 March 2021 and the opportunity to respond to recommendations made in response to the death of Cai Wheeler-Trow. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is committed to ensuring that pregnancy and birth are as safe as possible, and the College welcomes the opportunity to contribute.

In response to your investigation, the coronial findings and expert reports have been brought to the attention of the RANZCOG Women's Health Committee (the Committee), Council and Board.

The Coroner's recommendation one will be implemented.

The College has taken the Coroner's recommendation and has made the following changes to the RANZCOG statement Prevention, detection, and management of subgaleal haemorrhage in the newborn (C-Obs 28)

- The good practice point in the summary of recommendations has been further emphasised by elaborating that any second stage forceps or caesarean delivery requires a multifaceted approach.
- Additional information has been added to sections of the document regarding blood loss and the amount of blood that can accumulate in the subaponeurotic space and why it is difficult to detect.
- Further information has been added about the time of observations (1 – 6 hours) and other risk factors to be considered.
- Specific mention of scalp observations and head circumference as part of level two surveillance in the algorithm.

The Committee, however, felt that considering the situation - preterm baby with a prolonged attempt at instrumental birth, the baby should have been on level two neonatal surveillance and therefore, while acknowledging the treating staff's best intentions, feel that this is a failure of guideline implementation and not the guideline in itself. The Committee however also acknowledges the timing of such deliveries, which often happen late at night and are therefore associated with clinician exhaustion as well as that of the mother, possibly contributing to critical observations getting missed.

The revised guideline is currently out for further neonatologist consultation and the final version of the document will be available for view following RANZCOG Council and Board approval in the coming months.

I wish to thank you for the opportunity to provide feedback on these recommendations. Please do not hesitate to contact Ms Lakshmi Bondu, Women's Health Senior Co-ordinator (lbondu@ranzcog.edu.au or 03 9412 2920) should you have any queries or concerns.

Your sincerely

Dr Vijay Roach
President