Competing interests: None.

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F234 PostScript

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Variations in practice among paediatric consultants when referring unexpected neonatal deaths to a coroner

Despite advances in perinatal care, a few babies die unexpectedly at or soon after birth. The most likely cause is perinatal hypoxia. Sometimes the reason for this hypoxia is clear (such as ante-partum haemorrhage or obstructed labour). In other instances there may be no explanation for the event and questions may be raised whether the death could have been prevented. Although it is the norm for all centres to discuss all perinatal deaths in mortality and morbidity meetings, more recently, anecdotal it seemed that many units have been choosing to refer such cases to the coroner. These referrals can be stressful for the obstetric and paediatric teams as they may lead to a coroner’s inquest and extensive media scrutiny.

We conducted a survey of the practices of different neonatal units across the country with regard to referral to a coroner of unexpected neonatal death. An email questionnaire was sent to the lead consultants of 221 neonatal units in the UK, asking if they had referred any case of unexpected death to the coroner in the past five years, and if there was a lowering of the threshold for such referrals. The questionnaire included two clinical scenarios of unexpected neonatal death associated with birth asphyxia (box 1), and the respondents were asked if they would refer these deaths to a coroner. Two reminders were sent over a six-week period to those who did not respond.

A total of 62 consultants (28%) responded, of whom 60% had referred an unexpected neonatal death to the coroner in the past five years. Just over half (51%) felt that there had been a lowering of threshold for making such referrals. With regard to the clinical scenarios, 42% and 43% would have given a cause of death in cases 1 and 2, respectively, whereas 30% and 27%, respectively, would have referred the cases to the coroner. Twenty-one per cent were unsure about the answer in both cases, and 7% did not answer the case questions. The causes of death that the respondents would have given were intrapartum asphyxia, perinatal or peripartum asphyxia, birth asphyxia, hypoxic ischaemic encephalopathy or neonatal encephalopathy.

The results of our questionnaire survey represent the practices of just under a third of the neonatal units in the country. Even from these relatively small numbers, it is clear that there is confusion about what was expected in the case scenarios. Some respondents commented that they found the scenario confusing, and this pushed them to make the referral. Others were concerned about the additional distress to parents when such referrals are made. There is clearly a need to determine what is best practice and disseminate these guidelines to all neonatal teams across the UK.

Box 1 Cases included in the questionnaire

- Case 1
  - A 30-year-old multigravida is admitted in labour and delivers a term baby within 30 min of admission. The baby is born in poor condition and cannot be resuscitated. The cord pH is 6.7. There is no evidence of antepartum haemorrhage.
- Case 2
  - A 30-year-old primigravida is admitted in labour at 1400 hours. At 1900 hours the CTG [cardiotocograph] is found to be sub-optimal. The baby is delivered via emergency LSCS [lower segment caesarean section] after failed forceps. Time of birth is 2000 hours. The baby is born in poor condition and cannot be resuscitated. The cord pH is 6.7. There is no evidence of antepartum haemorrhage.

Interpretation of endocrine function in the newborn period can be difficult, and it is often an area of confusion. This book certainly clears the muddy waters. It offers concise and practical guidelines, and acts as a handbook with a hands-on, how-to approach.

The book itself is small and thin, and therefore not daunting. Unfortunately, the cover is somewhat unexciting and offers the only, if slightly mundane, photographs. The layout inside the book cannot be faulted. Each chapter covers a different endocrine problem. There are 25 of these in total, and they have a similar, clear format.

Practical neonatal endocrinology


Katie Malbon

CORRECTION
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A Trotter, L Maier, M Kron, et al. Effect of oestradiol and progesterone replacement on bronchopulmonary dysplasia in extremely pre-term infants (Arch Dis Child Fetal Neonatal Ed 2007;92:F94–8). The legend in figure 2 of this paper was published incorrectly. The filled bars are actually the Estra-Pro group and the open bars are the placebo group. Also, “bronchopulmonary dysplasia” is misspelt and should be “bronchopulmonary dyslipidaemia”. Finally, “ITT survivors” should have been amended to “ITT population (survivors)”. We apologise for these oversights.