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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 antepartum 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, anecdotally 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.

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 suboptimal. 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.

A total of 62 consultants (28%) responded, of whom 60% had referred an unexpected neonatal death to the coroner in the past five 5 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 45% 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 feared medicolegal consequences and litigation 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.

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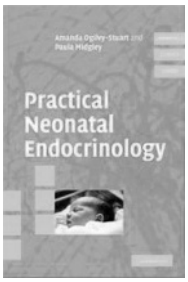
BOOK REVIEW

Practical neonatal endocrinology

Edited by Amanda Ogilvy-Stuart and Paula Midgley. Published by Cambridge University Press, Cambridge, 2006, £35.00 (paperback), pp 228. ISBN 0-5218-3849-5.



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.

The first section in each chapter is ''Clinical presentation''. Here each problem is listed in bullet points with a short explanation. The next is ''Approach to the problem''. This has a useful and practical paragraph outlining the order in which things should be done and also prioritises the clinical problems. This is followed by ''Differential diagnosis'' and ''Investigations''. The next section is ''Management'', which is usefully broken down into short, intermediate and long-term management. Each paragraph is clear and concise. ''What to tell the parents'' comes next. For me this is the most appealing section. Set-out in a clear manner, the authors emphasise the important points to relay to parents. It also includes useful links to other areas in the book and lists support groups or relevant websites. Finally each chapter has a ''Further reading'' section.

Most chapters include a flow chart. These charts clarify the pathway of investigation and management in what can be a fairly complex area. Again they are clearly set out and easy to read. Some chapters have additional sections relevant to the problem being discussed. These include ''Management at home'', which gives extremely useful and practical advice.

At the back of the book are five appendices. The first explains how to calculate the glucose infusion rate from both intravenous fluids and milk. This is shown in a graph format in addition to the calculation. The second appendix describes the dynamic tests. This is an invaluable section. Not only do the authors list the indication for certain tests but they also explain how the patient should be prepared for the test, how the procedure is performed, and how to interpret the results. Normal ranges are given in Appendix 3. Again a useful section, as neonatal ranges are rarely given by hospital laboratories. Appendix 4 is ''Biochemistry samples''. I am a little doubtful about using this as a reference as I think each laboratory differs, not only in the amount of blood required, but also in the turn-around times. I would not take this information at face value, and would certainly recommend contacting one's own hospital laboratory to confirm what sort of sample is required. The authors do emphasise that the table is only for guidance; in which case I wonder if it was necessary to include it. The final appendix is a formulary. This includes drugs required for dynamic tests as well as treatment doses, and is a useful addition.

Practical Neonatal Endocrinology does exactly what it aims to do. It is a clear, concise and extremely practical handbook which should be available not only in neonatal units but also in all general paediatric departments.

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 preterm 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, ''bonchopulmonary dysuplasia'' is misspelt and should be ''bronchopulmonary dysplasia''. Finally, ''ITT survivors'' should have been amended to ''ITT population (survivors)''. We apologises for these oversights.