LETTERS TO THE EDITOR

Unnatural sudden infant death

EDITOR,—There cannot be many paediatricians who are unaware that infanticide may pose as sudden infant death syndrome (SIDS); therefore, one must question the wisdom of Professor Meadow¹ in deciding not to let this sleeping dog lie, in the interests of ordinary parents induced by media coverage not only to worry about whether their sleeping babies will ever wake up but whether in that case they could be accused of murder. However, he does make an important point, and that is the desirability of postmortem examinations in such cases being carried out by experienced paediatric pathologists—a threatened species. It is regrettable that when in response to public concern about cot death the Medical Research Council considered establishing a Chair in this branch of pathology, they were dissuaded by the then President of the College of Pathologists. Fortunately the Foundation for the Study of Infant Deaths stepped into the breach, but it is anomalous that postmortem examinations in babies are still being carried out by general pathologists. In my view, the exposure of infanticide is less important than continuing research into other causes of sudden infant death; so far very successful in reducing the incidence to half of what it used to be as well as contributing to knowledge in other ways.

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1 Meadow R. Unnatural sudden infant death. *Arch Dis Child* 1999;80:7-14.

EDITOR,—The question, outlined by Meadow,¹ of which infant deaths have an unnatural cause is primarily a problem for the coroner's pathologist rather than the paediatrician. The great majority of these infants never come to the attention of a paediatrician before or after death, and it is the pathologist who is required to advise the coroner as to what should be entered on the death certificate. As someone who has had a specialised interest in this task for over a quarter of a century, the frequency of suspicion of homicide in the absence of physical injury is probably no more than 1% of the total.

I am aware of the argument that if I do not know the cause of death I cannot know that the infant has not been gently smothered. On the other hand, the principle that guilt has to be proven is a good one. Moreover, the curious uniformity of the clinical history and lack of pathology in these cases is a strong argument in favour of regarding sudden infant death syndrome (SIDS) as an entity distinct from homicide. Where either the history or the pathology is not typical of SIDS, it is always prudent to record that the cause of death is "unascertained". For these relatively rare cases, it is usually impossible for the pathologist, police or coroner to take matters further. Infant smothering is an unwitnessed

crime. Confessions are seldom volunteered and such is parental guilt surrounding any child's death that it is foolish to accept a confession without corroborative evidence. I remain sceptical that paediatricians are better at detecting homicide than an experienced member of the police service, especially as in most cases the child has never been a hospital patient. I wonder whether Professor Meadow would be enthusiastic about involving physicians in the investigation of possible homicide in unexplained deaths in adults. Dr Watson never showed the same aptitude for the task as Sherlock Holmes!

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1 Meadow R. Unnatural sudden infant death. *Arch Dis Child* 1999;80:7-14.

EDITOR,—The warning to meta-analysts published at the end of Professor Meadow's paper¹ was intriguing. The paper reports a highly selected, uncontrolled case series collected over 18 years with no reference to a denominator population. The paper would be excluded from any meta-analysis with appropriate inclusion-exclusion criteria independent of whether the same cases appeared in similar uncontrolled, highly selected case series.² Uncontrolled case series collected by tertiary specialists occupy the lowest level in the hierarchy of evidence based medicine. They have been responsible for misleading conclusions which, when taken up by the media, have had unfortunate consequences for child health. Two of the most notorious examples are the pertussis vaccination controversy in the 1970s³ and the more recent publication of a highly selected case series claiming to show a link between measles-mumps-rubella vaccination and autism.⁴

Professor Meadow's clinical descriptions and insights are fascinating and potentially useful to paediatricians. His suggestion that all unexpected infant deaths should be fully investigated including a "death scene investigation" is appropriate and justified on the basis of the cases he describes. However, his statement that "Currently, many paediatric units are failing to heed warning signs and failing to protect some very vulnerable children" is impossible to interpret in the absence of denominator data in his study and the protracted period over which the cases were collected. Professor Meadow's case series is a seriously flawed basis from which to mount an attack on the integrity of SIDS as a diagnostic category. Unfortunately, it is these latter conclusions of his paper that have received media attention and which may have the effect of causing unnecessary further distress to bereaved parents. A sound estimate of the proportion of sudden unexpected infant deaths attributable to, or suspicious of, infanticide can be obtained only by properly designed controlled studies within a defined population such as the CESDI (confidential enquiry into still-births and deaths in infancy) study.⁵ Unjustified and sweeping conclusions based on highly selected and uncontrolled case series are not only scientifically flawed but are potentially seriously misleading.

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- 1 Meadow R. Unnatural sudden infant death. *Arch Dis Child* 1999;80:7-14.
- 2 Southall DP, Plunkett MCB, Banks MW, Falkov AF, Samuels MP. Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics* 1997;100:735-60.
- 3 Kulenkampf M, Schwartzmann JS, Wislon J. Neurological complications of pertussis inoculation. *Arch Dis Child* 1974;49:46-9.
- 4 Wakefield AJ, Murch SH, Anthony A, et al. Ileal-lymphoid-nodular hyperplasia, non-specific colitis and pervasive developmental disorder in children. *Lancet* 1998;351:637-41.
- 5 CESDI. Confidential enquiry into still-births and deaths in infancy. *Fifth annual report*. London: Maternal and Child Health Research Consortium, 1998.

Professor Sir Roy Meadow comments:

As Professor Davis infers, it would be convenient and less stressful for us all to let sleeping dogs lie, and to avoid confronting the problem of infanticide. However, paediatricians have a responsibility to the other children in these families. Half of the 50 families whom I reported included more than one dead child, and within most of the other families there were children who incurred serious non-fatal abuse. Moreover, most of the 81 dead children had, in retrospect, features that could have led to intervention preventing their death. Therefore, we have to improve our recognition of children at great risk to protect them; and improve our recognition of infanticide to protect the siblings.

Professor Davis and Dr Barson agree with me about the importance of necropsy being performed by a skilled pathologist experienced with infants. However, we have moved on from the era when morbid pathology provided the gold standard for diagnosis. Today, clinical diagnoses are based primarily on the history, and supplemented by findings on examination and investigation. Indeed, many paediatricians base their diagnoses far more on the history than on examination or investigation findings. It is illogical to jettison that central basis of diagnosis, the history, when considering why a child has died. The history should be assessed by a paediatrician, because paediatricians are familiar with histories of childhood illness. Pathologists who are most expert at necropsies and tissue morphology may have had only eight weeks' experience as an undergraduate learning about paediatric diagnosis and illness. Criminal investigation department officers and coroners officers, for all their skills in other areas, have had even less experience. It is improper and unfair to give pathologists the responsibility for providing a quick diagnosis without the aid of a competent clinical history.

Amidst the hate mail that I have received recently have been some thoughtful letters from bereaved parents. Some have written of their surprise at the "casual and lax way" in which the death of their baby was investigated: "we really did feel that experts and the police should have looked into our house and our affairs much more thoroughly than they did and then we would have felt absolved of guilt." Others have written of their greatest sadness that they still do not understand why their child died: "if only there had been a clear reason we would have felt so much better." Those clear reasons, usually natural, but sometimes unnatural, are much more likely to come to light if all sudden deaths are subject to a multidisciplinary assessment, including a visit to the death scene, with involvement of not just an experienced pathologist,

but also a paediatrician, general practitioner, health visitor, and police officer.

My report was aimed at paediatricians to alert them to some of the features that may enable earlier detection of young children who are likely to be killed by their parents. The note at the end about the dangers of meta-analysis was based on past experience of having some of my observational studies inappropriately included in meta-analysis reports, and incorrectly reported in review articles. I have made clear in many publications, and to the media, that my work does not allow conclusions to be drawn about the proportion of infant deaths that are caused by parents. The most recent estimate from CESDI and other studies suggest that parental acts may be the main, or a contributory, cause of between 8% and 18% of infant deaths. That is a substantial number of deaths. Not only those children but also their vulnerable siblings, deserve better assessment and care.

Colonic wall thickness and pancreatic enzymes in cystic fibrosis

EDITOR.—The paper by Ramsden and colleagues¹ showed no evidence that colonic wall thickness differs in children with cystic fibrosis who take high or low strength preparations of pancreatic enzymes, or the product they used previously. They found that, on average, colonic wall thickness was greater in children with cystic fibrosis than in controls, which confirms the observations made by Oppenheimer and Esterley² more than 20 years ago (many years before any of the present enzyme formulations existed).

Despite these negative results, the authors seem to have accepted the hypothesis (which has little or no published evidence to support it) that there is a connection between colonic thickening, fibrosing colonopathy, and methacrylic acid copolymer Eudragit L30 D55. They state that this copolymer "in high doses has a toxic effect on the gut of animals", but give no reference for this statement. They also say that no association has been found between fibrosing colonopathy and Creon 25000 (which does not contain Eudragit) in the United Kingdom epidemiological study of fibrosing colonopathy.³ I was the chairman of that study, but, for the following reasons, was unhappy with the investigation and its published presentation. Firstly, the selection and inclusion of cases of fibrosing colonopathy rested on the opinion of a single pathologist who was not blinded to the treatment, and who has been the main proponent of the copolymer hypothesis. Although there were two other pathologists available for consultation, they were never allowed to see all the material submitted to the study, which included verified and possible cases. Therefore, there may be other cases of fibrosing colonopathy which were excluded from epidemiological analysis. Secondly, the lack of association between Creon 25000 and fibrosing colonopathy in cases that were included was true only for the months leading up to surgery. The pattern of enzyme use up to 12 months before operation showed that 11 of the 14 affected children were on Creon. No information was collected on why they changed from Creon to other preparations, but in the single published case which studied this, it was found that while on Creon there was a lack of response to abdominal symptoms, which persisted when the brand of

enzyme was changed.⁴ It was impossible in that case, as in most others, to identify exactly when the lesion of fibrosing colonopathy developed; nearly all cases were initially diagnosed with distal intestinal obstruction syndrome (DIOS) before the diagnosis of fibrosing colonopathy.

A review of the diagnostic criteria for fibrosing colonopathy and treatment for the disease is clearly needed. Ramsden *et al* have found no supporting evidence for the copolymer hypothesis, but their discussion suggests that they continue to believe it.¹ It is surprising that they made no reference to the authoritative American study which reports 29 patients with fibrosing colonopathy. This study confirms a strong correlation between fibrosing colonopathy and high daily doses of pancreatic enzymes, but found no link with the strength, coating, or manufacturer of the products.⁵ In my view, the epidemiological and pathological evidence should be reviewed by an independent team; unfortunately, the pathological material upon which the UK report was based cannot be found. Until an impartial investigation takes place, it is inappropriate to accept hypotheses which cannot be verified.

Conflict of interest: During the past few years, I have accepted consultation fees and hospitality from all of the companies marketing pancreatic enzymes in the United Kingdom—that is, Solvay, Cilag, and E. Merck. At present, I am a consultant to Scandipharm (USA).

JOHN A DODGE

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- 1 Ramsden WH, Moya EF, Littlewood JM. Colonic wall thickness, pancreatic enzyme dose and type of preparation in cystic fibrosis. *Arch Dis Child* 1998;79:339–43.
- 2 Oppenheimer ER, Esterley JR. Pathology of cystic fibrosis, review of the literature and comparison with 146 autopsies. *Perspectives in Pediatric Pathology* 1975;2:241–78.
- 3 Smyth RL, Ashby D, O'Hea U, *et al*. Fibrosing colonopathy in cystic fibrosis: results of a case control study. *Lancet* 1995;346:1247–51.
- 4 Campbell CA. Comment on: Campbell CA, Forrest J, Musgrove C. High-strength pancreatic enzyme supplements and large-bowel stricture in cystic fibrosis [letter]. *Lancet* 1994;343:109. *Postgrad Med J* 1996;72(suppl 2):S11.
- 5 Fitzsimmons SC, Burkhart GA, Borowitz D, *et al*. High-dose pancreatic-enzyme supplements and fibrosing colonopathy in children with cystic fibrosis. *N Engl J Med* 1997;336:1283–9.

Dr Ramsden and colleagues comment:

We are pleased that Professor Dodge accepts our finding that the children in our study, who had cystic fibrosis and who had received high strength pancreatic enzymes containing methacrylic acid copolymer Eudragit L30 D55 (MAC), had a similar colonic wall thickness to controls.¹ However, this finding does not exonerate MAC as an important causative factor in the rare cystic fibrosis patient who develops fibrosing colonopathy. However, our results are reassuring because they do not support the suggestion that there are now many cystic fibrosis patients who have subclinical colonic damage, as a result of taking high strength pancreatic enzymes.²

We do not accept Professor Dodge's statement that there is "little or no published evidence" to support the link between fibrosing colonopathy and MAC. Published, individual case reports in which enzyme brands are identified, show that all patients with pathologically confirmed fibrosing colonopathy have received MAC coated products at some

stage.^{3–11} There are no reports of patients with pathologically confirmed fibrosing colonopathy taking solely non-MAC coated products. A detailed analysis of the patterns of use of pancreatic enzymes in fibrosing colonopathy shows that the condition has occurred only in patients taking MAC coated enzymes for at least six months.¹⁰ The UK epidemiological study, of which Professor Dodge was a co-author, found a significant dose related association with only MAC coated brands.¹¹ We consider that the design of the North American study could not show brand difference, as the controls came from the same cystic fibrosis centre as the index case and, thus, risk factors that varied systematically between centres were missed.¹² Experimental data show submucosal fibrosis in pigs after seven days of exposure to MAC,¹³ and fibrosing colonopathy-like changes after chronic exposure to the coating.¹⁴ Therefore, we cannot accept the contention that there is little evidence to support the role of MAC in fibrosing colonopathy.

In the single published case mentioned by Professor Dodge, it was clearly shown that growth failure occurred when the child was switched to Nutrizym 22, but not while taking Creon 25 000.¹⁵

There are obvious differences of opinion about the role of MAC in causing fibrosing colonopathy, and, despite the wealth of supporting evidence, we support the proposed review of the existing evidence by independent experts. This is particularly important for cystic fibrosis patients who continue to take MAC containing pancreatic enzyme preparations that are still available in the UK (Pancrease HL and Nutrizym GR), and which are widely used in the United States.

- 1 Ramsden YM, Moya EF, Littlewood JM. Colonic wall thickness, pancreatic enzyme dose and type of preparation in cystic fibrosis. *Arch Dis Child* 1998;79:339–43.
- 2 McSweeney EJ, Oades PJ, Rosenthal M, *et al*. Relation of thickening of colon wall to pancreatic enzyme treatment in cystic fibrosis. *Lancet* 1995;345:752–6.
- 3 Campbell CA, Bush A, Heaf D, *et al*. Case reports. *Postgrad Med J* 1996;72(suppl 2):S11–29.
- 4 Fallick JS, Drugas GT. Residents clinic: 3-year old boy with cystic fibrosis and abdominal pain. *Mayo Clin Proc* 1997;72:697–82.
- 5 Hausler M, Meilicke R, Biesterfeld S, *et al*. First adult patient with fibrosing colonopathy. *Am J Gastroenterol* 1998;93:1171–2.
- 6 Jones R, Franklin K, Spicer R, *et al*. Colonic strictures in children with cystic fibrosis on low-strength pancreatic enzymes [letter]. *Lancet* 1995;346:499.
- 7 Knabe N, Zak M, Hansen A, *et al*. Extensive pathological changes of the colon in cystic fibrosis and high strength pancreatic enzymes [letter]. *Lancet* 1994;343:1230.
- 8 Pettei MJ, Leonidas JC, Levine JJ, *et al*. Pancolonic disease in cystic fibrosis and high-dose pancreatic enzyme therapy. *J Pediatr* 1994;125:587–9.
- 9 Stevens JC, Maguiness KM, Hollingsworth J, *et al*. Pancreatic enzyme supplementation in cystic fibrosis patients before and after fibrosing colonopathy. *J Pediatr Gastroenterol Nutr* 1998;26:80–4.
- 10 Bakowski MT, Prescott J. Patterns of use of pancreatic enzyme supplements in fibrosing colonopathy: implications for pathogenesis. *Journal of Pharmacoepidemiology and Drug Safety* 1997;6:347–58.
- 11 Smyth RL, Ashby D, O'Hea U, *et al*. Fibrosing colonopathy in cystic fibrosis: results of a case control study. *Lancet* 1995;346:1247–51.
- 12 FitzSimmons SC, Burkhart GA, Borowitz D, *et al*. High-dose pancreatic enzyme supplements and fibrosing colonopathy in children with cystic fibrosis. *N Engl J Med* 1997;336:1283–9.
- 13 Van Velzen D, Ball LM, Dezfulian AR, *et al*. Comparative and experimental pathology of fibrosing colonopathy. *Postgrad Med J* 1996;72(suppl 2):S39–48.

- 14 Lannon CL, Ball LM, van Velzen D. Gross colonic submucosal fibrosis equivalent to fibrosing colonopathy in adolescent pigs exposed to Eudragit L30D55, a chronic toxicity study [abstract]. *Proceedings of the 18th Annual Meeting of the American College of Toxicology* 1997;112.
- 15 Campbell CA. Comment on: Campbell CA, Forrest J, Musgrove C. High-strength pancreatic enzyme supplements and large-bowel stricture in cystic fibrosis [letter]. *Lancet* 1994; 343: 109. *Postgrad Med J* 1996;72(suppl 2):S11.

BOOK REVIEWS

Primary Health Care Guide to Common UK Parasitic Diseases. By Figueroa J, Hall S, Ibarra J. (Pp75 plus inserts). Community Hygiene Concern, 1998. ISBN 0 953 31440 5.

On balance, I think I was flattered when given a book to review featuring head lice. I was caught short for appropriate slides the other day when asked to teach the senior house officers (SHO) something about paediatric dermatology, so I decided to produce home made examples of warts, atopic eczema, and, you guessed, pediculosis capitis. The Editor was subsequently fed accounts of a mad general practitioner casually demonstrating the art of extracting a dozen or so beasts from her youngest offspring. It was worth it for the SHOs' looks of horrified fascination alone.

I presume it was felt that sharing this book with me would promote public health among North Oxfordshire schoolchildren. Indeed it has. Scarcely had I started leafing through the pages on head lice—clearly laid out, comprehensively but unobtrusively referenced, common myths unemotionally and objectively assessed—when I realised that this, like *Delia Smith's Christmas*, was a book I had been looking for all my life.

Entire pages have been copied (the authors helpfully say you are allowed to) and handed to parents at our village school. For the first time in years the annual parents' evening was not dominated by heated discussions on head lice.

Our health visitors think it's great and want me to hurry up and finish this article so that they can borrow the book from the practice library. The importance of patient education has been clearly thought out. For example, there is a patient information sheet on head lice designed to fit into a standard format, parent held child health record.

The authors submit conventional treatment to close scrutiny. This highlights the limitations and potential dangers of prescribing by historical precedent. I had not appreciated the lack of evidence of efficacy of malathion for scabies, stuff I prescribe by the gallon.

The format of the book is simple and very effective. Each chapter covers a different parasite and is printed on different coloured paper. There is a useful glossary at the end, which enables the book to be understood by a non-medical reader. This is, however, no glossy practice coffee table book. There are no frills and, refreshingly, no grateful ac-

knowledgements to pharmaceutical companies. A decision has apparently been made to sacrifice flashy binding for the benefit of keeping the price down. The only drawback of this otherwise wholly admirable policy is that the resolution of the photographs could be sharper.

The book does not try to be comprehensive. It only considers parasites found in the UK, and is selective about these. The editors state, however, that they plan to increase the breadth covered in future editions.

This book is a valuable and authoritative document. Its value can be estimated by the fact that the cover of my copy is getting extremely grubby. Need I say more?

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Allergy and Allergic Diseases—The New Mechanisms and Therapeutics, edited by Denburg JA. (Pp 591; US\$145, £106.) New Jersey: Humana Press, 1998. ISBN 0 896 03404 6.

For many years, it was not entirely respectable in medical circles to admit to an interest in allergy, a view supported by the plethora of quasi scientific approaches to the identification of allergies, and reinforced by the apparent lack of success of so many interventions designed to prevent or treat allergy. However, allergy is gradually losing its shady reputation and in recent years scientific understanding of the subject has progressed by leaps and bounds. This information has not, however, been particularly accessible to jobbing clinicians, and Denburg's intention in producing this book is to highlight the interface between basic and clinical science.

This is not a book for the clinician seeking to update himself on allergy practice. Although it does cover the pathogenesis of the major allergic disorders, and concludes with a section on treatment, these chapters focus on the underlying science rather than clinical practicalities, and it is fair to say that the book is biased towards basic rather than clinical science.

The first thing I did on receiving the book was to look up a few favourite topics in the index; peanut allergy was nowhere to be found, nor were urticaria, eczema or even asthma. After a few further thwarted attempts to find topics of interest, I realised that the book had been bound with the wrong index—apparently from a treatise on pain—the man at the pulping machine at Humana Press is no doubt at this very moment filling in his overtime claim!

The index is the only thing wrong with this book. Once that problem is sorted out it will be of interest to clinicians dealing with allergic disorders, and seeking a comprehensive review of the cellular and molecular basis of allergic inflammation. Given the complexity of the subject, it is a remarkably easy book to read. Each chapter is freestanding and copiously illustrated, providing a comprehensive review of a single topic. Readability is enhanced by editorial acceptance that overlaps are inevitable, which in the case of my indexless copy was just as well. Speaking of which, I never did find anything about peanut allergy, but all the other topics were covered.

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WESTMINSTER BRIEFING

The following items are from *Children & Parliament*, winter 1998/spring 1999. *Children & Parliament* is an abstracting service based on *Hansard* and produced by the National Children's Bureau. It covers all parliamentary business affecting children and is available on subscription via the internet (<http://candp.ncb.org.uk>). The *Children & Parliament* web site provides direct links to full text *Hansard*, government department sites, the sites of the Office for National Statistics, Ofsted, and other relevant organisations. For further details contact Lisa Payne, Editor, *Children & Parliament*, National Children's Bureau, 8 Wakley Street, London EC1V 7QE, UK (tel: +44 (0) 171 843 6000; fax: +44 (0) 278 9512). (The *Hansard* reference is given in parentheses.)

- All school pupils in England and Wales are protected against corporal punishment under section 131 of the School Standards and Framework Act 1998. It will be for the Scottish Parliament and the Northern Ireland Assembly to decide whether to extend this protection to other parts of the United Kingdom.

(16 Dec 1998, Col 153–4.)

- Sixteen to 18 year olds who are unintentionally homeless and vulnerable must be given priority by local housing authorities but the Department for the Environment, Transport, and the Regions does not provide any specific assistance.

(16 Dec 1998, Col 534.)

- Under new arrangements for 1998–99 Disabled Students Allowances for young people in full time further and higher education will no longer be means tested and the amounts claimable have been increased.

(16 Dec 1998, Col 549–50.)

- Schools that provide milk for their pupils must charge all parents for it except those who receive income support or income based job-seekers allowance.

(17 Dec 1998, Col 389, 677.)

- A bill to set up a disability rights commission received its second reading in the House of Lords. A majority of commissioners will be disabled people and their duties will be to combat discrimination against disabled people and to promote equal opportunities. They will keep under review the workings of the Disability Discrimination Act. When the commission is established the National Disability Council will be abolished.

(17 Dec 1998, Col 1461–97.)

- In response to a question about government commissioned research into attention deficit hyperactivity disorder the Minister of State for Public Health referred to work on treatment at Kings College Hospital, London, studies on cognitive and behavioural strategies at the MRC Child Psychiatry Unit in London, and genetics studies at the

Institute of Psychiatry and the University of Manchester.

(14 Jan 1999, Col 250–1.)

- From September 1999 children in primary schools will have daily mathematics lessons of up to an hour. A pilot study on reading skills showed that children performing below average gained ground by some 8–12 months in 2 years with a daily “literacy hour”.

(14 Jan 1999, Col 257, 250.)

- A joint working group of the Departments of Health and of Education and Employment will consider how to improve speech and language therapy provision for children with special educational needs. They will also take on board other therapies such as physiotherapy.

(19 Jan 1999, Col 427.)

- The new National Family and Parenting Institute will be an independent charity and will set its own terms of reference. It already has a work programme for its first year which will be government funded.

(20 Jan 1999, Col 106–7.)

- The National Screening Committee is expected to report during 1999 on whether universal neonatal hearing screening should be introduced.

(21 Jan 1999, Col 550–1.)

- A new Bill will recognise the need for new adoptive parents to take time off work to be with the children so that parents and children can adapt to their new family life together.

(21 Jan 1999, Col 541.)

- The new National Family and Parenting Institute will be required to make sure that its services are relevant to, reach, and are taken up by, ethnic and racial minority organisations.

(25 Jan 1999, Col 69–70.)

- The Prison Service is developing new standards for the care of young people under the age of 18 in prison. Guidance on the prevention of suicide in prisoners is to be reexamined.

(26 Jan 1999, Col 200–1.)

- The government insists that it is still necessary from time to time to mix young

offenders and adult prisoners contrary to the UN Convention on the Rights of the Child.

(27 Jan 1999, Col 250.)

- An amendment to the Children Act 1989 will mean that an unmarried father who registers his child’s birth jointly with the mother will automatically acquire parental responsibility. At present unmarried fathers can only acquire such responsibility either by agreement with the mother or by obtaining a court order.

(27 Jan 1999, Col 159.)

- NHS Direct is a 24 hour telephone helpline staffed by nurses. Three pilot schemes, in Milton Keynes, Preston, and Newcastle began in March 1998 and by December they had received over 60 000 calls, some 40% of which were about children, usually from young mothers. Independent research showed that almost all (97%) callers were satisfied with the service. Plans to cover 60% of the country by April 2000 have been brought forward to December 1999 and the government is to add another £10 million from the NHS modernisation fund to the £44 million already promised for the financial year 1999–2000.

(2 Feb 1999, Col 727–35, 1436–45.)

- The government’s new national strategy for people who care for sick or disabled relatives or friends includes: a £140 million grant to local authorities to fund breaks for carers, council tax reductions for adapted homes, new information about carers from the 2001 census, plans to help carers get back to work, promotion of carer-friendly employment, provision for young carers including help at school, more help for disabled children, and more training about young carers for social workers.

(8 Feb 1999, Col, 21–33, 27–39.)

- A network of “Childcare Champions” has been set up by the Benefits Agency to help with the provision of childcare services.

(16 Feb 1999, Col 678–9.)

- Summer schools to improve numeracy and literacy in children are being expanded. The 1999 plan is for 300 schools and 9000 pupils to take part in the numeracy project and for 900 schools and 27 000 children to participate in the literacy scheme.

(9 Mar 1999, 10 Mar 1999, Col 103, 219–20.)

- As a result of the Programme of Action for meeting special educational needs it is expected that more children with such needs will be able to attend mainstream schools. Nevertheless the government sees a continuing and vital role for special schools.

(10 Mar 1999, 11 Mar 1999, Col 218–19, 314.)

- During 1999 the government is to issue guidance to local authorities about their responsibilities towards children leaving their care. New legislation will impose a duty to assess and meet the needs of care leavers until they are 18 and possibly, later, until they are 21. All authorities are expected to provide care leavers with a simply written guide to available services.

(11 Mar 1999, Col 86.)

- A motion urging for more to be done to help children who care for others was signed by 103 Members of Parliament.

(15 Mar 1999, Early Day Motion no. 432.)

- Fifty-one Members of Parliament have signed a motion in support of the NSPCC campaign against child abuse.

(16 Mar 1999, Early Day Motion no. 434.)

- Agreement has been reached on two new European Community Directives, which set strict limits on pesticide concentrations in infant formulae and baby foods.

(16 Mar 1999, Col 638.)

- Youth offending teams are being piloted in 16 local authorities and are to be introduced in all areas of England and Wales by April 2000.

(16 Mar 1999, Col 590.)

- Under the Carers (Recognition and Services) Act 1995 carers have a right to be assessed. General practitioners and primary care teams should inform carers about this right and the Carers National Association has launched an “Ask for an assessment” campaign. The number of assessments made will be a social services performance indicator.

(17 Mar 1999, Col 724–6.)