between infection and the sudden infant death syndrome suggest another possibility for intervention. Thus preventing pertussis by improving the uptake of immunisation and avoiding infection in infants under 6 months of age could have benefits.^{18 19}

In countries that seek to optimise the environment of babies and mothers before and after birth infant mortality from all causes (including the sudden infant death syndrome) is low.^{20 21} Infant mortality (both from all causes and from the sudden infant death syndrome) is high in socioeconomically deprived families.²² The implications of this are obvious, although the financial costs of reversing the effects of deprivation would be high.

Although apnoea monitors have been promoted by several organisations, they miss most life threatening episodes of hypoxaemia.²³ British paediatricians reported 64 deaths occurring in the home despite infants being on such monitors

(personal observations). A transcutaneous monitor, which is 100% sensitive in detecting hypoxaemic episodes, is now available for infants at high risk of sudden death.²³

Several strategies that might reduce the incidence of the sudden infant death syndrome are therefore available. We believe that further evidence of the potential benefits of improving the socioeconomic environment of the baby before and after birth should be sought urgently. The effectiveness of a recently mounted campaign to modify babies' sleeping position and thermal environment and parents' smoking habits remains to be determined.

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Relabelling blood

Read new labels carefully

From 1 April black and white labels will replace the coloured labels used to identify blood groups in the United Kingdom. This represents a step towards the goal of uniformity of labelling blood worldwide, sought by the committee on automation and data processing of the International Society of Blood Transfusion. Because countries could not agree an international colour code the committee recommended the adoption of black and white labels.

The United Kingdom now joins Canada, (civilian) Germany, the Netherlands, Norway, and the United States in having black and white labels. Elsewhere a wide range of conflicting colours persists. Group O blood is labelled green in Belgium, blue in Denmark, and red in France. A yellow label denotes group A in Italy, group B in France, and group AB in Denmark.

Why change? The deployment of multinational forces in the Gulf war highlighted the potential for confusion during emergencies. When stressed, people tend to choose blood from a refrigerator by the colour of the label rather than by what it says. There is also a civilian interest in achieving uniformity as transporting red cells across national boundaries may become more common with the European single market.

Blood group labels on packs containing red cells and other products (for example, platelets) are overstick labels—that is, they are attached to the right hand side of the manufacturer's pack label when the blood group of the donor is known. In the United Kingdom a minimum requirement was that there should be a standard position for the information given on the

label. "Expiry date" will be at the top of the label. Below the blood group (ABO and Rh) and the regional blood transfusion centre will be recorded both sets of information in written and bar code form. The "Date bled" will be immediately below this information.

Also from 1 April the Rh type on most red cell packs will refer to the Rh D group only. Thus, red cells will be labelled Rh D positive or Rh D negative, which will meet most requirements. Additional Rh typing to provide further information concerning the Rh group will be performed at regional transfusion centres, and these specially typed units of red cells will be available when required.

During the next few weeks this important change in labelling will receive wide publicity. Posters will be available in hospitals together with a leaflet illustrating the change to black and white labels. Both of these measures will supplement discussions between staff in transfusion centres and

hospitals on the implications for hospital practices of the changes in labelling.

Countries that have changed from coloured to black and white labels have done so successfully. Even if an international colour coding agreement was achieved in the future, reverting to coloured labels may not be popular as black and white labels can be readily printed in house. The discipline of reading the blood group on the label instead of looking at the colour may not be so readily accepted as an advantage. It must be conceded, however, that this principle is one that accords with good clinical practice. It is no different from the well recognised practice of reading the name of a drug on the container before giving it.

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What mentally ill offenders need

All their carers marching to the same tune

Nearly 20 years after the Glancy and Butler reports recommended new psychiatric facilities for treating mentally abnormal offenders^{1,2} scandal and mishap keep the subject on the political agenda. Reports of mentally ill offenders in prison,³ of unacceptable delays in transferring patients from special hospitals,⁴ and of inadequate follow up after patients' discharge from hospital are common and sometimes tragic.⁵ More than 10 years have elapsed since the Royal College of Psychiatrists emphasised the need for treatment to be available in settings that provide a range of security according to clinical need.⁶ Recently the government seems to have rediscovered mentally abnormal offenders. We are instructed that mentally ill offenders should be diverted from prosecution and not imprisoned,⁷ services for those who are in prison should be improved,⁸ and agencies dealing with mentally abnormal offenders should coordinate their work.⁹

Few would disagree with these statements of principle. So why, now, another government document?¹⁰ Last week marked the end of an 11 week consultation period for a review by the Department of Health and the Home Office of services for mentally disordered offenders and others with similar requirements.¹¹ A cast of 41, including only seven hands on psychiatrists, assembled in three advisory groups and a steering committee under the chairmanship of Dr John Reed, senior principal medical officer. The review deals solely with services in England.

There are reports concerning hospital, community, and prison services and an overview. Their principal objective is that mentally disordered offenders needing care and treatment should receive it from health and social services rather than in custodial care; at present, we are reminded, "practice all too often falls a long way short of what is desirable." The review makes 87 recommendations with five criteria in mind. Care should be provided on the basis of individual need, as far as possible in the community, near to the patient's home, only at the level of security justified by the patient's dangerousness, and with the aim of maximising rehabilitation and the prospect of independent living. Psychiatrists would vote for all that as they would for the abolition of sin.

Missionary zeal is maintained in the specific recommendations. Prosecution of mentally abnormal offenders should be

avoided. Local policies should be agreed by police, health, social, and probation services for the use of section 136 of the Mental Health Act 1983 (removal of a mentally disordered person to a place of safety), and appropriate facilities should be identified as places of safety. There should be a single and consistent point of access, available 24 hours a day, to health and social services. There should be more specialised bail facilities in the community, and defendants should not be remanded in custody solely for medical reports to be obtained.

Deficiencies in prison and hospital services are identified. Psychiatric services in prisons should be contracted out to the NHS in line with the recent proposals for general medical services.¹² Closure of mental hospitals is unacceptable in the absence of provision in the community of a range of services for former inpatients, each of whom should have an agreed care plan. Local psychiatric services should include access to wards providing intensive psychiatric care and to locked wards.

Provision should be made for patients who require long term care in a secure environment but would be inappropriately placed in a regional secure unit or special hospital. The national provision of beds in regional secure units should increase from the current 635 to 1500. Special hospital resources should not be changed at present.

How are these uncontentious, unoriginal, but highly desirable recommendations to be implemented? They involve a range of diverse organisations learning to march to the same tune. Reed proposes an action plan: local assessments of need, the setting up of a "permanent national focus," and dissemination of examples of good practice (for example, some of the court liaison schemes described in the review). General psychiatrists and their managers in district services, for whom the review has major implications, will wait with interest for the second phase of the review, which is considering finance, staffing, and training. Putting Reed's report into effect will not be easy. The fractious years that followed the Butler report provide lessons: regions and districts failed to understand the problems¹³; mentally abnormal offenders lacked influential advocates; ring fenced money was plundered; there were insufficient skilled staff; and regions fortunate