To wait to see the effects of referral committees may result in many unnecessary deaths.—I am, etc.,

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1 Pringle, M. K., *Proceedings of the Royal Society of Medicine*. In press.
2 Carpenter, R. G., and Emery, J. L., *Nature*, 1974, **250**, 729.

SIR,—The Brighton committee of inquiry into the death of Maria Colwell, keeping to its brief, has formulated an excellent report[1] which pinpoints deficiencies in the co-ordination of agencies; but examination of the evidence shows that the lack of co-ordination was a subsidiary cause of the tragedy. The crucial decision to remove the child from her affectionate foster-parents did not call for co-ordination between the agencies, nor did the decision by the court to support the return of the child to her natural parents. The second crucial decision, to leave the child in a situation of hazard, arose from the misinterpretation of abundant immediate data. Co-ordinating the information of other agencies was irrevelant. A number of agencies had supporting evidence, but the unavailability of this evidence did not prevent neighbours coming to the right conclusions. Society, as your leading article (14 September, p. 641) states, did not fail, but the experts did. Using the public, the system, and the lack of co-ordination of agencies as scapegoats will not deceive informed opinion. We must look elsewhere than to lack of co-ordination of agencies for the cause of the tragedy. It lay in matters unhappily outside the terms of reference of the inquiry—in the theoretical viewpoints that guided decision making.

The main wrong viewpoints were: that the natural parents are, in all circumstances, more adequate than other parents; that children should be returned to natural parents at the first opportunity; that foster-parents cannot supply totally satisfactory substitute care; that separation of children from parents is to be avoided at all costs. A monopolistic State machinery that maintains these viewpoints deliberately places large numbers of children at hazard in their own homes. This prescription for the management of child care produces an iatrogenic disorder.

The prescription for change must include the following.

(1) Changes of viewpoints about the essentials of child care which need to be taught to the relevant professions. The Brighton minority report gives an embarrassing picture of the bizarre, fanciful shibboleths rife in training schools.

(2) A national inquiry with wide terms of reference into child care procedures. Each death by battering (three more were reported in the *Daily Telegraph* on 17 September) deserves a local inquiry, but a national inquiry could have wider terms of reference.

(3) The provision of a specialist social worker in child care, responsible for the supervision of children, for maintaining a confidential list of vulnerable children, and for collaboration with other professionals. Team work is admirable but secondary to careful evaluations of the family situation. Team responsibility should not replace individual responsibility. The trust of families can be retained only with confidentiality.

(4) Any child admitted to hospital and suspected of being a victim of abuse should be referred to a psychiatrist, as is now the practice with attempted suicide. The psychiatrist would then undertake extensive family exploration and would collaborate with the medical man in continuous medical responsibility and with a social worker in continuous welfare responsibility for families.

(5) Area teams should consider children's services only broadly, as they are too slow and indecisive to be concerned in day-to-day case management and cut across the essential requirement of individual responsibility.

(6) The legal position of children should be strengthened. Foster-parents should be represented in courts as a right. A "children's advocate" is likely to represent established expert opinion and would not have saved Maria Colwell. Better to put our faith in detached, careful magistrates, who are usually more in touch with common sense and public opinion. Courts can seek the opinion of a child psychiatrist when a detailed exploration of family pathology is required.

(7) Children's voluntary societies should be strengthened to the point of being effective innovators and a realistic alternative to the state care of our children.—I am, etc.,

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1 *Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell*. London, H.M.S.O., 1974.

Reporting Deaths to the Coroner

SIR,—I am grateful to Dr. C. F. J. Baron (21 September, p. 740) for drawing attention to the opinion obtained by the B.M.A. in 1942.[1] That opinion was based on the statement of the law which appeared in the contemporary edition of *Jervis on Coroners*,[2] for which counsel claimed there was "plenty of judicial authority." As he gave no references to these we are thrown back on references given in the edition of Jervis from which he quoted, but these are all concerned with the indictable misdemeanour of obstruction of the coroner and not with any common-law duty.

Having given no more authority for the existence of a common-law duty than a reference to Jervis, counsel argued that "unless a statutory provision can be found which expressly, not implicitly, overrides this particular duty, the duty is still binding on a medical practitioner." Counsel also claimed that "until the passing of the Births and Deaths Registration Act, 1926, no medical man seems to have questioned his obligation to report to the coroner any death into which the coroner ought to inquire." This suggests that counsel was unaware of the repeated references to the controversy which had appeared before 1926 in medical journals and that he was also unaware of its frequent mention in parliamentary papers before that date, including the reports of select committees, departmental committees, and Bills, some of which attempted to resolve the issue by placing a statutory duty on doctors to notify the coroner.

It is hardly surprising that the 1943 opinion from Sir Roland Burrows was so decisive and that subsequent editions of Jervis have stated the law correctly—that is, there is no duty enforceable at common law on a doctor (or any other person "about the deceased") to notify the coroner of deaths coming within his jurisdiction.

Dr. Baron claims that "in the absence of a judicial decision, there must be room for more than one view." It is difficult to see why he should prefer an opinion which is based on a false assumption that judicial decisions do exist.—I am, etc.,

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1 *British Medical Journal Supplement*, 1942, **2**, 25.
2 *Jervis on the Office and Duties of Coroners*, ed. F. Danford Thomas, 7th edn., p. 21. London, Sweet and Maxwell, 1927.

Dangers of Oxytocin-induced Labour to Fetuses

SIR,—Messrs. W. A. Liston and A. J. Campbell (7 September, p. 606) were wise to draw attention to the very real risks to the fetus associated with the injudicious use of oxytocin, but the conclusions drawn from their retrospective study are not supported by their results. No significant difference was demonstrated between the frequencies of fetal distress, low Apgar scores, or admission of babies to the special nursery when high or low doses of oxytocin were used during labour. No other valid comparison could be made because of the differences between the groups of patients studied. It is probable that a large proportion of abnormal pregnancies and labours were included within the group of oxytocin-stimulated labours, which biased the results towards a greater incidence of neonatal asphyxia in this group. The only conclusion which might reasonably be drawn from these results is that the dose of oxytocin used to "stimulate" labour did not appear to influence the condition of the neonate at birth when judged by the parameters chosen.

This observation is supported by the results of my own previously unpublished *prospective* series of 510 patients in which labour was induced artificially by amniotomy and simultaneous intravenous oxytocin. All were between 38 and 42 weeks pregnant with a cephalically presenting fetus and were more than 152 cm tall. This degree of selection was necessitated by the main purpose of the investigation, which was totally unrelated to the study of fetal well-being, but no selection was made for age, parity, abnormality of pregnancy, or indication for induction. The patients were divided into two groups, those in the first receiving oxytocin in low doses (maximum 16 mU/min) regardless of uterine activity, while in the second group oxytocin was titrated in rapidly increasing doses against the amount of uterine activity. A fetus was considered to be asphyxiated if an Apgar score of less than six was recorded either at one or 10 minutes after birth. Low doses of oxytocin were used to induce 200 labours, and 11 (5·5%) of the neonates had low Apgar scores. Titrated oxytocin was employed in 310 patients with the result that 23 (7·4%) of the neonates had low Apgar