logist. The parents cannot accept that their child is backward, and they have an instinctive mistrust of psychologists. They have heard of dyslexia and latch on to the idea that their child might have it. Dyslexia is a popular and acceptable thing to have whereas being backward is not. They consult the family doctor, who refers the child to the local paediatrician. Constraints of time make the general paediatric clinic unsuitable for the assessment of these children. The general practitioner may also refer the child to the senior clinical medical officer in the School Health Department. He or she will have wide experience of the range of special educational needs.

The consultant paediatrician can perform a neurological examination to rule out obvious organic neurological pathology. A developmental assessment may be performed, but this is time consuming. It will, however, certainly be carried out if the senior clinical medical officer is present, as should be the case in an assessment unit or in joint assessment clinics. Listening to the parent and taking a meticulous history of the child and family are also time consuming but vitally important. At the conclusion the parents can be counselled that the person most qualified to decide whether the child actually has dyslexia, dyscalculia, etc is in fact the educational psychologist, who is also in a position to determine educational needs. He or she may institute a multidisciplinary assessment (Education Act 1981) to which the above mentioned doctors will be able to contribute.

Another problem is that local branches of the Dyslexia Institute (who employ their own educational psychologists) give the impression in their leaflets firstly, that dyslexia is common and that any one of a large number of learning problems may point to it, whereas some educational psychologists in the local education authority service feel it is very rare. Secondly, there are implications that its management requires completely different teaching techniques (available at the institute) from those of school 'remedial teaching' and that the latter may do harm in these children. The psychologists need to reach an agreement on this issue.

Reference

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Inquiries into perinatal and early childhood deaths in a health care district

Sir,

Professor Brimblecombe and colleagues describe a method of monitoring peri- and post perinatal deaths.¹ The reader

might gain the impression that this is a new aspect of research. Many areas have monitored post perinatal deaths and confidential enquiries were recommended as early as 1970. Confidential enquiries into post perinatal deaths have been carried out in Sheffield since 1973, and in 1979 became part of routine health services.^{2,3} The importance of the Exeter study lies in combining peri- and post perinatal deaths. We found that 13 of a total of 101 post perinatal deaths were the result of 'perinatal causes', and this proportion seems to be increasing. Brimblecombe dealt with only 62 deaths: larger health districts with over 100 deaths annually have more problems. When we attempted to extend into the perinatal period we found that the necessary staff were not available. Brimblecombe is aware of the financial problems and has made this the subject of recommendations elsewhere. Could he expand on this?

In our enquiries an evening home visit is now always made by a doctor rather than a nurse, but our greatest advance has been to hold the case conference on non-hospital deaths in the family doctor's surgery, and we strongly recommend this. Surgery based conferences are usually attended by at most six people with direct involvement and produce information that would not be presented at hospital conferences. Hospital doctors also gain understanding of community problems.

Regarding audit; confidential information should result in improvements in services. We find that the best method is to hold regular meetings with senior medical and nursing administrators to discuss the results of all case conferences. Changes in services are initiated and confidentiality is maintained without a public report.⁴ We believe that it is only through confidential enquiries that understanding of at least some cot deaths will be attained.

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Professor Brimblecombe comments:

I am sorry if any reader gained the impression from our paper that I regarded confidential inquiries into perinatal and early childhood deaths as a new subject for research. There are so many well known published reports on this topic that I had not thought it necessary to append a full