

LETTERS TO THE EDITOR

Where should paediatric surgery be performed?

EDITOR,—Arul and Spicer's recent review¹ on this controversial issue failed to address some of the most important points surrounding regionalisation of paediatric surgery. Other papers on the subject are equally unrewarding^{2,3} and so perhaps there is a need for more debate.

We must balance the need to banish "occasional paediatric practice"⁴ with the rightful concerns about providing "a child and family centred service in which skilled help is readily available and accessible".⁵

The arguments used by the authors on centralisation of paediatric intensive care do not necessarily support the need to regionalise paediatric surgery along the same lines. Paediatric intensive care is a low volume, high risk speciality requiring the skills and equipment justified in only a few UK centres. In contrast the vast majority of surgery on children in the UK is low risk, high volume work very, little of which requires on site specialist paediatric facilities. Paediatric surgery is however attended by significant morbidity if the wrong decisions are made; such morbidity may only be revealed several years later.

Nevertheless we are urged to move towards a model where one paediatric surgical centre serves the specialist surgical needs of a population of 2.5 million and the non-specialist needs of 1.2 million. The remaining 1.3 million children with non-specialist needs in this model would be served by the general surgeon with a paediatric interest (a rare breed according to a recent Senate of Surgery report⁶). However, according to guidance issued by the British Association of Paediatric Surgeons to purchasers² such centres might be responsible for cases such as elective repair of congenital inguinal hernia, undescended testis, and circumcision. Arul and Spicer are rightly concerned that the skills required to deal with these problems are considerable if long term morbidity is to be prevented.

In a larger district general hospital such as Norwich, 3000 children under 12 have operations each year. A large proportion of this work is done by two paediatric surgeons. This gives the surgeon, anaesthetist, and more importantly managers the numbers to provide extra facilities and produce a first rate local service for children. As well as medical staff it involves a dedicated, separate provision for children from operating theatre, recovery room, and day care centre to the provision of pain relief, and beyond. Removing our paediatric surgeons would have a significant spin off effect in making the total provision of service less cost effective and more prone to inadequate investment.

If we all believe that children's surgery should be done by paediatric surgeons (as happens in most developed countries) it is nonsense to make plans of which the main side effect is so much surgery being done by a dying breed of general surgeons with a paediatric interest.

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- 1 Arul GS, Spicer RD. Where should paediatric surgery be performed? *Arch Dis Child* 1998;79:65-72.
- 2 British Association of Paediatric Surgeons. *Guidance to purchasers*. London: BAPS, 1995.
- 3 Royal College of Paediatrics and Child Health. *Childrens surgical services*. London: RCPCH, 1996.
- 4 *National enquiry into perioperative deaths*. London: NECPOD, 1989.
- 5 *Fit for the future*. Report of the court committee on child health services. London: HMSO, 1976.
- 6 *The provision of general surgical services for children*. London: Senate of Surgery of Great Britain and Ireland, 1998.

Mr Arul and Spicer comment:

Drs Wilkinson and Crowle seem to have missed the central tenet of our paper, which is the importance of distinguishing between general and specialist paediatric surgery. While a specialist paediatric surgeon should help to train and advise general surgeons with an interest in paediatric surgery, there are guidelines published for surgery and anaesthesia to be safely performed in a district general hospital.^{1,2}

The raison d'être of the paediatric surgeon is specialist surgery. Almost by definition this type of surgery requires neonatal and paediatric intensive care as well as a support structure that includes specialist radiologists, pathologists, and nurses. The 3000 children that Wilkinson and Crowle state are operated on in Norwich probably include a large number of "ear, nose, and throat" and non-specialist general surgical operations. The most important data to consider is how many neonates and infants are involved and how many required intensive care postoperatively?

The last set of figures that were published by the British Association of Paediatric Surgeons shows that Norwich operated on 50 neonates a year while Cambridge, within the same region, operated on 20 neonates.³ Hence both centres are seeing fewer than the 60 surgical neonates considered essential to maintain expertise.⁴ If, however, they were to combine then there would be a viable centre. The benefits would be immediate. Instead of working a one-in-two on call rota with no middle grade specialist registrar cover, the consultants could organise a much more acceptable rota. The paediatric surgeons could start to develop further special interests; appropriate training of specialist registrars could begin; anaesthetists could start to organise themselves into a paediatric on call rota; and ward nurses would start to see sufficient numbers of high risk complex surgical cases to gain essential experience.

The point of our paper was not to "take away their paediatric surgeons" but rather to suggest that with careful organisation of a service on a regional basis, all hospitals in their region would be better served with both specialist and non-specialist paediatric surgery.

- 1 *National enquiry into perioperative deaths*. London: NECPOD, 1989.
- 2 *Guidance for purchasers of paediatric anaesthesia*. London: Royal College of Anaesthetists, 1994.
- 3 *Training handbook*. London: British Association of Paediatric Surgeons, 1992.
- 4 British Association of Paediatric Surgeons. *A guide for purchasers and providers of paediatric surgical services*. Edinburgh: The Royal College of Surgeons of Edinburgh, 1995.

Height and weight pattern in very long term survivors of childhood acute lymphoblastic leukaemia

EDITOR,—Birkebæk and Clausen reported auxological data in very long term survivors of acute lymphoblastic leukaemia (ALL) in first complete remission.¹ We also evaluated long term survivors of childhood cancer, including acute leukaemia.² To compare our data with those of Birkebæk and Clausen we used the same selection criteria. Twelve of 26 survivors received chemotherapy (C) alone and 14 chemotherapy plus cranial irradiation (C + I). Median age at diagnosis, at the end of treatment, and at evaluation were similar to Birkebæk and Clausen's patients (5.3 v 4.3, 8.1 v 7.25, and 19.3 v 20.5 years, respectively).

Poor nutritional status at diagnosis (-1.01 body mass index standard deviation score (BMISDS) for the C group and -1.03 for the C + I group) improved during treatment (-0.23 and 0 BMISDS for each group at the end of treatment). We confirm the frequency of obesity (31% for the whole group); however, we found a tendency to higher figures in group C + I compared with group C (43% v 17%), as well as a higher proportion of obese girls than boys (39% v 12.5%). The sample size precludes achieving significance. We suspect, based on our personal experience over 25 years caring for children with cancer, that parental health and illness constructs may influence the acquisition of eating habits of survivors.

At diagnosis, we also found that patients were taller than the normal population (0.42 and 0.27, mean height standard deviation score (HSDS) in the C and C + I groups, respectively). At evaluation mean HSDS were, respectively, -0.42 and -1.02 for the C and the C + I groups. Mean height loss since diagnosis was -0.84 and -1.29, respectively. In contrast, almost all survivors had achieved their target height. Accordingly, corrected mean height loss for their target height (calculated as HSDS at evaluation minus target HSDS) reduced the differences between diagnosis and evaluation to 0.17 HSDS for the C group and -0.34 HSDS for the C + I group. Height loss in the C group was observed by Sklar and colleagues,³ but not by others.^{1,4,6} Birkebæk and Clausen's results would be interpreted better if they included target height in their analysis. Few studies have contrasted final height of survivors with their target height.^{4,7} As a result, height loss appears greater than that genetically expected so clinicians may overemphasise the adverse effect of cancer treatment (especially cranial irradiation) on survivors' height.

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- 1 Birkebæk NH, Clausen N. Height and weight pattern up to 20 years after treatment for acute lymphoblastic leukaemia. *Arch Dis Child* 1998;79:161-4.
- 2 López-Andreu M. Evaluación bio-psico-social de los supervivientes, a largo plazo de cáncer pediátrico. Doctoral Dissertation. Universitat de Valencia, 1998.
- 3 Sklar C, Mertens A, Walter A, Mitchell D, Nesbit M, O'Leary M. Final height after treatment for childhood acute lymphoblastic leukemia: comparison of no cranial irradiation with 1800 and 2400 centigrays of cranial irradiation. *J Pediatr* 1993;123:59-64.

- 4 Holm K, Nysom K, Hertz H, Müller J. Normal final height after treatment for acute lymphoblastic leukemia without irradiation. *Acta Paediatr* 1994;83:1287-90.
- 5 Hokken-Koelga A, van Doorn J, Hällen K, Stijnen T, de Muinck Keizer-Schrama S, Drop S. Long-term effects of treatment for acute lymphoblastic leukemia with and without cranial irradiation on growth and puberty: a comparative study. *Pediatr Res* 1993;33:577-82.
- 6 Caruso-Nicoletti M, Mancuso M, Spadaro G, Dibenedetto S, DiCataldo A, Schilirò G. Growth and growth hormone in children during and after therapy for acute lymphoblastic leukaemia. *Eur J Pediatr* 1993;152:730-3.
- 7 Cicognani A, Cacciari E, Vecchi V, et al. Differential effects of 18- and 24-Gy cranial irradiation on growth rate and growth hormone release in children with prolonged survival after acute lymphocytic leukemia. *Am J Dis Child* 1988;142:1199-202.

Drs Birkebeck and Clausen comment:

Lopez-Andreu *et al*'s patient group was comparable with our group regarding age at treatment and age at follow up and they found the same frequency of obesity as we did; however, Lopez-Andreu *et al* did not mention changes in BMISDS from attained final height until follow up.

Mean height standard deviation score (HSDS) loss since diagnosis in the C + I group was -1.29 similar to the HSDS loss in our population of -1.27. In the C group, however, Lopez-Andreu *et al* found a mean HSDS loss since diagnosis of -0.84 while HSDS in our C group was the same at diagnosis and follow up. Lopez-Andreu *et al* did not describe the treatment regimen, which might have been more intensive than our C group regimen, explaining the discrepancy. Sklar *et al* using more intensive treatment than us, also found a final HSDS loss in the C group, while Holm *et al*, who used the same treatment regimen as us did not find any final HSDS loss in a group treated with chemotherapy only.^{1,2}

Lopez-Andreu *et al* found that most of the patients attained their target height and proposed a corrected mean height loss for the target height (HSDS at final height minus target HSDS) when evaluating the impact of treatment on final height. We calculated mean height loss for target height in our population of patients treated for ALL in childhood. C group patients reached their target height, but for the C + I group mean target height was significantly higher than final height. Thus the corrected mean height loss for the target height was -0.64. Using this number the HSDS loss since diagnosis was -1.29 compared with an HSDS loss of -1.27 when not taking target HSDS into consideration. We cannot confirm the findings of Lopez-Andreu *et al* of a decreased target HSDS of patients treated for ALL in childhood with C + I.

- 1 Sklar C, Mertens A, Walter A, Mitchell D, Nesbit M, O'Leary M. Final height after treatment for childhood acute lymphoblastic leukaemia: comparison of no cranial irradiation with 1800 and 2400 centigrays of cranial irradiation. *J Pediatr* 1993;123:59-64.
- 2 Holm K, Nysom K, Hertz H, Müller J. Normal final height after treatment for acute lymphoblastic leukemia without irradiation. *Acta Paediatr* 1994;83:1287-90.

Position paper on the use of botulinum toxin in cerebral palsy

EDITOR.—Contrary to the statement by Carr *et al* that botulinum toxin is currently unlicensed for use in the treatment of patients with cerebral palsy,¹ we would like to inform your readers that the Botox brand of botulinum toxin (Allergan, High Wycombe, Bucks, UK) is currently licensed for the treatment of cerebral palsy as follows:

In hospital specialist centres with appropriately trained personnel, of dynamic equinus foot deformity due to spasticity in ambulant paediatric cerebral palsy patients, two years of age or older.

Botox is currently the only brand licensed for this indication.

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- 1 Carr LJ, Cosgrove AP, Gringras P, Neville BGR, on behalf of the UK Botulinum Toxin and Cerebral Palsy Working Party. Position paper on the use of botulinum toxin in cerebral palsy. *Arch Dis Child* 1998;79:271-3.

BOOK REVIEWS

Pediatric Radiology. By Joanna J Seibert, Charles A James. (Pp 633 paperback.) Thieme, 1998. ISBN 0-86577-697-0.

Putting together a book of radiology cases is fraught with difficulties. Should the cases be of rare and unusual conditions that one might come across once in a working lifetime so that one may recognise them, or should most of the cases be of the more mundane variety to reinforce the appearance and details of cases we are exposed to regularly? The answer is of course both and getting the right balance is a difficult task. The authors of this collection of cases do strike a comfortable balance and have obviously thought carefully about which cases to include. They have included cases from all fields of paediatric radiology and have used a broad spectrum of imaging modalities from plain radiographs to complex interventional procedures.

The layout is impressive and easy to read. The book is divided into several body systems with a section on syndromes and interventional radiology. Each case has a useful subsection of "pearls", "pitfalls", and "controversy", which include relevant facts about a condition, the imaging problems incurred, and caveats about making the diagnosis using the imaging techniques shown. This is well constructed and makes extracting new information about an otherwise common condition easier than ploughing through accompanying text. Each case is accompanied by an impressive list of references.

As with any radiology text the reproduction of images is a disappointment. Plain radiographs and ultrasound images do not lend themselves to textbook images, which is frustrating and does let down several of the cases.

Radiology trainees, particularly those interested in paediatric radiology, stand to gain most from reading this book. Although paediatricians would find it enjoyable and informative, its relevance to their day to day practice would be limited.

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Neurofibromatosis Type 1 in Childhood. By Kathryn North. (Pp 132; £27.95 (US\$47.95) hardback.) Mackeith Press, 1997. ISBN 1-898-68313-1.

This review must begin with a declaration of conflict of interest! There are only three other currently published texts purely on neurofi-

bromatosis and I am a coeditor of one of them. However, as I was initially trained as an adult physician before going into clinical genetics, I have to start by saying that Kathryn North, as a paediatric neurologist, provides a different and important perspective to clinical studies of neurofibromatosis type 1 (NF1).

The book is a volume in the *International Review of Child Neurology* series. It is based on the experience gained in establishing a neurofibromatosis clinic at the Royal Alexandra Hospital for Children in Sydney, Australia. Dr North wrote the entire text apart from the chapter on molecular biology of NF1, which is a well written summary of the state of the art in this field by David Gutmann.

The other six chapters and appendices are all about clinical aspects of NF1 with an emphasis on the neurological aspects, particularly optic gliomas and the developmental and learning problems seen in children with this condition. The highlight of the book for me was an extremely practical description of how to go about setting up a children's clinic: the appendices contain all the clinic proformas that would be extremely useful in this respect.

The sections on cognitive function and optic gliomas in NF1 are excellent. They contain a detailed literature review and then Dr North's own studies, which have been an important contribution to the field. The book ends with a helpful discussion about the role of cranial magnetic resonance imaging (MRI) in management. The subject of whether patients should have a routine cranial MRI at the time of diagnosis has long been disputed. Dr North concludes that currently there is no place for screening MRIs in the routine clinic and only recommends scans when there are particular clinical indications. She makes the point however, and I quite agree, that there is still a place for continuing evaluation of the routine use of this technique in the research setting. For example, if a marker could be found as to exactly which children with optic nerve changes on MRI were going to progress to some level of visual problem it would be extremely important, and perhaps newer techniques such as PET scanning will give us the answer.

This book is clearly an essential addition to the shelves of all those of us that regard ourselves as neurofibromatologists. Perhaps in my own early work I underplayed the value of specialist clinics as I felt that the American model of running such clinics was overplaying the severity of the condition for families. However, now I have run a fairly low key specialist clinic for nearly a decade, I feel that there is a role for regional neurofibromatosis clinics. I suspect that also there are sufficient cases such that if each district or community paediatric service designated one paediatrician to look after all of them, the general burden of the cognitive problems (occurring in between 30% and 50% of children) so elegantly described by Dr North would become more apparent and the children given better support. This book is a must for anybody wanting to undertake this challenge and for paediatric neurologists, on whom the burden of assessing children with the more severe cognitive problems and neurological complications falls.

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Consultant Clinical Geneticist

Recent Advances in Paediatrics 16. Edited by T J David. (Pp 236 paperback; £35.) Churchill Livingstone, 1997. ISBN 0-443-05960-8.

If a wealthy philanthropist wanted to improve the care delivered to children at a stroke he might consider sending a copy of *Recent advances in paediatrics* to every paediatrician; better still, he might accompany each with a letter purporting to come from the *Archives* asking them to review it, thus ensuring that it would be read! As in previous editions, Professor David has managed to assemble a remarkably broad selection of topics and authors, striking a careful balance between science and clinical practice, between neonatal, general, and community areas, and between international themes and UK relevance. The diverse authors mostly produce an accessible and readable style, the illustrations are clear, and particularly helpful are the "key points" boxes at the end of each chapter.

The first chapter on necrotising enterocolitis describes this still puzzling condition very thoroughly, noting that its pathogenesis remains elusive, and that early breast milk rather than formula feeds may be protective. The King's team review biliary atresia, distinguishing the minority "embryonic" from the majority "perinatal" type, and reminding us of the importance of early diagnosis and referral to a tertiary centre; some more practical advice on local screening policies for prolonged neonatal jaundice would have been helpful here. The third chapter on screening for congenital dislocation of the hip (CDH) is thoroughly depressing: two thirds of children with CDH are currently missed by screening, there has never been good evidence to support either clinical or ultrasound screening, and many normal babies are splinted unnecessarily. Next, a multidisciplinary team from Montreal, Canada describe ways of helping the feeding impaired child from a largely behavioural perspective. In the fifth chapter, Lyme disease in children is comprehensively described by a team from Connecticut, USA where the disease first cropped up: diagnosis and investigation can be difficult but treatment is easy and we need to remain vigilant. Another worrying "new" pathogen is dealt with in chapter 6, *Helicobacter pylori*: its epidemiology and degree of association with symptoms are quite different in children from adults, and there are some huge international variations; this chapter would have been improved by some more practical advice on when and how to look for this organism in children with abdominal symptoms.

The traditional chapter on a "tropical" subject this time deals with the convincing evidence in favour of the introduction of insecticide treated mosquito nets in malarious areas. Although of no relevance in the UK, I found it fascinating in the critical way it deals with comparisons of morbidity and mortality data from different studies, and the economic arguments.

The next two chapters are related, dealing with the genetic basis of asthma and the immunopathogenesis of allergic disease. Both are complex with much science, but the principles are clearly explained, and the speculations about possible future prevention and treatment of atopic diseases are intriguing. Chapter 10 categorises psychosocial problems in epilepsy, reminding us of their extent and the need to refer difficult cases. In Chapter 11, Canadian authors compare their experience of attempts to prevent adolescent

substance abuse with that of the USA and UK: they conclude that most programmes show little evidence of effectiveness, and suggest targeting identifiable groups of vulnerable young children. The final contribution reviews what has recently been learnt about sodium homeostasis from advances in molecular biology, allowing clearer classification of conditions such as Bartter's syndrome and pseudohypoaldosteronism.

Every edition of *Recent advances in paediatrics* ends with Professor David's commendably wide ranging review of a year's paediatric literature, this one 1996. His one line résumés may be galling to the authors who see years of labour summed up in a few words, but they are a boon to busy clinicians. He quotes many review articles, and it would be even better if he could attempt to precis these as well as the original papers.

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WESTMINSTER BRIEFING

The following items are from *Children & Parliament*, summer and winter 1998. *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.)

- Projects in Russia, Guyana, and Zimbabwe were given by the Secretary of State for International Development as examples of the Department's support for education on human rights. The Department also supports education in international humanitarian law. (1 Jun 98, Col 37.)
- Scandinavian research has suggested a population prevalence for Asperger syndrome of 36 per 10 000. The National Autistic Society's estimate for the UK is 47 400 children with Asperger syndrome. (1 Jun 98, Col 142.)
- Suicide is the second most frequent cause of death in men aged 16 to 25. The government aims to cut suicides by 17% by the year 2010. Strategies include restricting pack sizes for paracetamol and aspirin, support for projects such as the "Manchester campaign against living miserably" which aim to improve communication with at risk groups, and general practitioner education. (2 Jun 98, Col 156-57.)
- The government is providing support for the first wave of Health Action Zones to the tune of £5.3 million in 1998-99 and £30 million from 1999-2000. (2 Jun 98, Col 170.)

- The government is not planning to introduce a Children's Rights Commissioner but will keep an eye on progress in other countries where such an office has been established. (2 Jun 98, Col 175.)
- In answering a question about sudden unexpected death in epilepsy the Under Secretary of State for Health pointed out that the organisation Epilepsy Bereaved? has been given a £45 000 grant and invited to submit a bid for a national audit of epilepsy services. (5 Jun 98, Col 407-8.)
- A guide to good practice in foster care and a training pack for foster carers who are relatives or family friends of the children being cared for should both be available by the Spring of 1999. The former is being prepared by the UK Joint Working Party on Foster Care and the latter by the National Foster Care Association. (5 Jun 98, Col 409-10.)
- The Hague Convention on the Civil Aspects of International Child Abduction 1980 was reviewed in 1997 and the government has since promoted international judicial and administrative contacts to improve the operation of the Convention. (11 Jun 98, Col 656.)
- Guidance to be issued by the Department for Education and Employment in late 1998 will emphasise the importance of primary school education in developing skills necessary to resist being drawn into experimenting with drugs. (11 Jun 98, Col 693.)
- The Vaccine Damage Payment Scheme is to be reviewed along with other disability benefits. The government's intention is to increase the payment from £30,000 to £40,000 as soon as parliamentary approval can be obtained. (15 Jun 1998, Col 116.)
- A Childcare Unit has been established in the Department for Education and Employment. The minister responsible for national childcare strategy in England is the Under Secretary of State for Education and Employment, Welfare to Work. Ministers in the Scottish, Welsh, and Northern Ireland Offices deal with childcare issues in those parts of the UK. (15 Jun 98, Col 80; 19 Jun 98, Col 346-7.)
- In March 1997 there were 14 600 children on child protection registers in England, 8200 thought to be at risk of physical injury alone, 5600 at risk of sexual abuse alone, and 800 at risk of both. (16 Jun 98, Col 162-3.)
- In 1996-97 more than half of draft statements of special educational need took longer than the statutory 18 weeks before they were served on parents. The Department for Education and Employment has asked local authorities with poor records in this respect for their plans for improvement. (22 Jun 98, Col 410-11.)
- In 1990 there were 5897 cases of tuberculosis in the UK. In 1993 the figure was 6564 and the provisional figure for 1997 is 6430. The number of known cases of drug resistant tuberculosis was 43 in 1994, 49 in 1995, and 60 in 1996. (23 Jun 98, Col 116-17.)

- The draft order to increase vaccine damage payments from £30 000 to £40 000 was agreed.
(29 Jun 98, Col 122, 508–16.)
- A European Community directive bans all tobacco advertising aimed at young people. Plans to implement the Directive in the UK will be set out in a White Paper.
(30 Jun 98, Col 171.)
- About 250 million children throughout the world have to work, most of them without pay. This includes beggars, child prostitutes, and bonded workers who are, in effect, slaves. International plans are being made to stop the abuse.
(1 Jul 98, Col 205.)
- Although the government is relaxing curriculum requirements for several subjects, swimming instruction for primary school pupils remains essential as a matter of safety.
(2 Jul 98, Col 264.)
- An amendment to a new Bill will ensure that children with a statement of special educational needs will be educated in mainstream schools whenever it is compatible with the child's educational needs and the parents agree.
(2 Jul 98, Col 939–45.)
- Research at the University of Essex has shown that in the year after family break up the average income of mothers (excluding maintenance payments) falls by about 15%, while that of fathers increases by the same amount.
(3 Jul 98, Col 312.)
- Consumption of "alcopops" fell between 1996–97 and 1997–98 by about 30%.
(6 Jul 98, Col 340–1.)
- The government is assessing the use of electronic tagging of 10–15 year olds. So far 10 orders have been issued for children in this age group.
(13 Jul 98, Col 12.)
- The government's estimate is that some 4–6% of children have asthma severe enough to need medical supervision and about 21% of children have had a diagnosis of asthma at some time in their lives.
(14 Jul 98, Col 157.)
- The government is concerned about low rates of breast feeding, especially among low income families and is funding research into determining factors.
(14 Jul 98, Col 16–17.)
- Government health expenditure will be increased by £21 billion for the next three years and education expenditure by £19 billion. These are the main outcomes of the government spending review announced by the Chancellor of the Exchequer.
(14 Jul 98, Col 187–211, 129–51.)
- The British government is considering helping the Brazilian police with a witness protection scheme to shelter people who provide information about the murderers of street children in Brazil.
(14 Jul 98, Col 175.)
- Corporal punishment in children's homes, foster care, and registered care homes is illegal but private foster carers are not prevented by law from using it. The Department of Health is looking into safeguards for children in private foster care.
(16 Jul 98, Col 50–1.)
- An extra £3 billion is to be allocated to social services over the next three years. According to the Secretary of State for Health major aims are "breaking down the Berlin wall between the NHS and social services" and "to improve the quality of care received by children living away from home".
(16 Jul 98, Col 406–19, 571–85.)
- A system of licensing of medicines for children has been introduced in the USA. New European guidelines came into operation in September 1997. The pharmaceutical industry is encouraged to develop medicines for children and, for products which are likely to be beneficial for children, clinical trial evidence on children should be submitted to the regulatory authorities as soon as possible. Further powers may be sought within the European Union if companies fail to respond to the guidelines.
(20 Jul 98, Col 407–8.)
- In a debate about left-handedness in children the school standards minister said that, "teachers should bear in mind the fact that left-handedness is an important facet of some children and must be taken into account when planning lessons".
(22 Jul 98, Col 1085–93.)
- There are 64 mother and baby places distributed between four UK prisons. In July 1998 51 places were occupied.
(3 Sep 98, Col 8.)
- The School Standards and Framework Act 1998 imposes a duty on head teachers to determine measures to prevent bullying among pupils.
(6 Oct 98, Col 322–36.)
- Each year about 43 000 children under 16 run away from home but there are only three refuges for them. The government is looking at refuge provision as part of its response to the Utting report.
(21 Oct 98, Col 1436–8.)
- The Navy has become the last of the three services to decide not to employ personnel below the age of 17 in operational service. Recruitment and training at 16 will continue.
(22 Oct 98, Col 1161, 83.)
- A small-scale research project commissioned by the Department for Education and Employment will look into the costs, benefits, and practicalities of educating children with moderate learning difficulties in mainstream schools. The government holds that there are strong educational, moral, and social reasons for educating children with special educational needs with their peers.
(29 Oct 98, Col 233–4.)
- The Department for International Development is funding research and education in an attempt to end the practice of female genital mutilation in developing countries.
(2 Nov 98, Col 299–300.)
- The government's action programme for children with special educational needs (SEN) published in November, is five pronged; more support for parents and carers, better framework for SEN provision, more SEN children in mainstream schools, more staff training and education, and partnership for SEN, local, regional, and national.
(3 Nov 98, Col 531; 4 Nov 98, 591–2.)
- The Utting report's main recommendations, as summarised by the Secretary of State for Health, include: £375 million over the next three years as funding; a criminal records agency to improve police checks on applicants for posts with children; councils' responsibilities to extend up to age 18 and beyond; targets for better school attendance and performance for children in care; fewer and more suitable placements; more and better trained foster parents; better regulation for children's homes, residential schools, and independent foster agencies; a new national group for those currently or previously in care; easier "whistleblowing"; and increased protection for children who are witnesses in court.
(5 Nov 98, Col 1011–23, 375–86.)
- In a House of Lords debate a British Medical Association estimate was quoted to the effect that over 3000 young girls in Britain each year undergo female genital mutilation (female circumcision). The leading campaign organisation, FORWARD, claims that up to 15 000 girls are at risk.
(10 Nov 98, Col 730–50.)
- It is estimated that by 2002 some 66% of 3 year olds will be taking part in pre-school education.
(11 Nov 98, Col 236.)
- The action programme for special educational needs will receive £60 million of government money in 1999–2000. All local education authorities will be expected to develop parent partnership schemes and the government will introduce legislation if necessary.
(16 Nov 98, Col 411–12, 542; 17 Nov 98, 1091–3; 19 Nov 98, 757.)
- According to the Office of National Statistics publication, *Sudden infant deaths 1993–1997*, the SIDS' rate in England and Wales was 0.65 per 1000 live births in 1996 and 0.61 in 1997.
(17 Nov 98, Col 546.)
- The official requirements for the care of mothers and babies in prisons will be updated and amplified during 1999.
(18 Nov 98, Col 163.)
- Unless they are given an absolute discharge or a custodial sentence young people appearing before a youth court for the first time and pleading guilty will automatically be referred to a youth offender panel. A contract will be drawn up which will include reparation to the victim or to the community and measures aimed at drug or alcohol abuse, poor parenting, or other relevant issues.
(18 Nov 98, Col 609–10; 19 Nov 98, 204–5.)
- The Medicines Control Agency is considering reports of suspected adverse reactions to measles–mumps–rubella vaccine and has commissioned a study into MMR vaccine and autism.
(7 Dec 98, Col 66–7.)
- Tobacco advertising on billboards and in the printed media will be ended during this parliamentary session. There is to be a renewed antismoking campaign, further action to prevent sales to children, a new criminal offence of repeated sales to children, a proof of age card, and new restrictions on cigarette vending machines.
(10 Dec 98, Col 479–89, 1051–66.)