Eighty-five per cent of coroners replies suggested that no alternative arrangements were enforced following deaths after possibly suspicious circumstances — the consensus appeared to be a rigorous implementation of the guidelines which are already in place. Coroners were sensitive to the medicolegal aspects, with 82% feeling that this aspect of the inquiry was important. Five were aware of cases of litigation concerning the quality of resuscitation. No modifications to guidelines were felt to be necessary by most coroners for cases of sudden death on hospital wards.

Two factors determine the need for retention of devices in the body after death. Firstly, the question of whether the retention of such evidence for post mortem examination aids the pathologist in accurately identifying the cause of death. Many cases of sudden death in A&E departments occur as a result of identifiable causes such as myocardial infarction, cerebrovascular disease and respiratory disease. However, in cases of death by accident or in suspicious circumstances, each item of information may be of use to the investigating authorities. Therefore, the retention of evidence of medical intervention will help clarify the situation. Furthermore, the process of resuscitation itself is being examined more closely as medical negligence cases continue to go to court. However, in the more straightforward cases of sudden death which still require post mortem, often for purely legal reasons, one must ask whether there is a need to retain medical equipment.

The second is the emotional element in the laying out of bodies which still bear the trappings of aggressive medical intervention. A more enlightened approach to the management of the bereaved in A&E departments has led to a greater inclination to allow relatives to see the body of their loved one soon after death. It was apparent in the replies from coroners that this featured prominently in their thoughts, for example:

Pathologists in general have begun to appreciate that there are problems concerning the preparation of the recently deceased in as much as there is often a desire by the relatives to see, perhaps even touch, their recently deceased family member in order to aid the grieving and bereavement process.

It is popularly felt that relatives should be spared the pain of seeing their loved ones disfigured by medical apparatus, yet a school of thought now feels that it can, in some cases, be beneficial to the bereaved to see and fully appreciate the reality of the situation. So what are we to do for the best?

It appears from this study that, in those replying to the enquiry, there is a general desire on the part of coroners for standardization of the procedures for the early care of the body after sudden death. While this will aid their work it is likely that if a rigorous policy were to be implemented nationwide for all cases of sudden death, it would probably cause much discussion amongst the caring professions. The need for the implementation of a set of national guidelines to reduce confusion can only be met by debate and discussion of the various factors that are at play.

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The Health of the Nation: ‘Where do the children play . . . .?’

In 1830 the Book of Accidents: Designed for Young Children was published by an unknown author as an aid for parents and guardians to be used in instruction for their children.1 Using drawings and brief descriptions many childhood accidents were well described, and in each case preventative measures were detailed. Sadly over a century and a half later the same instructions, with only slight changes in language are still appropriate. Every week in England and Wales 17 children die as a result of accidents, a further 250 are admitted to hospital, and ten times more are taken to accident and emergency (A&E) departments for treatment; these figures represent an unnecessary toll on the life and health of children. Decades of health education, publicity and nationwide campaigns such as ‘Play it Safe’ on BBC Television, have done little to diminish this toll, and evidence suggests that the overall incidence of childhood accidents has not altered greatly during the past 20 years. Nevertheless, many of these accidents are preventable as accidents that children have often reflect their stage of development, making them more predictable by adults.

Many facts relating to childhood accidents are known, and have been known for some time. For example, certain types of accidents are more common in specific age groups, boys over the age of 2 consistently suffer more accidental injuries of all
types than girls and there is a steep social gradient in child accident fatalities.2

Effective prevention requires concerted efforts by individuals, organizations and industries to increase the safety of homes, schools and streets. Safety features that conform to British standards, for example, spark guards and nursery fire guards, electrical circuit breakers, thermostatic limitation on tap water temperature and smoke alarms, can be fitted in most houses, supported, if necessary, by legislation. Although the latter is no guarantee of domestic safety, it at least provides some protection for the most vulnerable members of society.

So what more can be done? It is time for each Health District to develop a new preventative strategy based on local data. Health Authority managers, through their community physicians and information officers with the help of local authorities, will have access to local epidemiological data of childhood accidental injuries. Computerization of A&E records will make it possible for a detailed epidemiological picture of the incidence of child accident injuries to be built up. Childhood accident prevention should then be put firmly on each Health Authority agenda as a continuing problem, requiring regular evaluation and monitoring. Concurrently, health visitors should be encouraged to promote accident prevention within families, since people tend to respond best to simple specific advice that is directly relevant to their own homes. The advantage of local action lies in the possibility of directly affecting policies and priorities by raising public awareness, educating parents and children, and heightening individuals’ and the community’s sense of responsibility to care for and protect children. It is time for health professionals to spend as much time and effort on preventing childhood accidents as they do on treating them. The new Children Act has improved, if not revolutionized, the rights of each child in our society. This offers little protection against the hostile environment in which they grow.

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REFERENCES

Passive digit hyperextension in the diagnosis of flexor tendon injuries

The clinical diagnosis of flexor tendon injuries requires active patient cooperation and may be difficult, especially if the patient is under the influence of alcohol or other drugs, mentally retarded, or in severe pain. Also it may be difficult to assess children and those with whom the examiner cannot communicate because of language problems.

I wish to describe a simple clinical test which I find useful in the diagnosis of acute flexor tendon injuries and does not require active patient cooperation.

I have applied this test on 33 consecutive patients with wounds on the volar wrist, palm or fingers of the hand in whom there was doubt about the presence or absence of flexor tendon injury when first seen. The test consists of gently and passively hyperextending the PIP and DIP joint of each finger being tested and, in the case of the thumb, the IP joint. Flexor tendon injury was diagnosed whenever there was alteration in tone on passive hyperextension as compared with the uninvolved digits in either the same or opposite hand. A characteristic sensation of easy giving was elicited on gentle extension of the joint being tested from its resting position.

This did not imply an increased range of hyperextension at this joint, just an alteration in resting tone. The results are shown in Tables 1 and 2.

The tone in any joint depends on the contractile state of opposing muscle groups. Normally when the joint is stretched passively in one direction the musculotendinous unit opposing this action contracts. If the musculotendinous unit is injured this contraction is impaired which produces an alteration in tone. As alluded to above, active flexion testing is not always reliable. The resting posture of the digits involved may not be altered with isolation injuries of FDS or partial flexor tendon injuries. A tenodesis test, in which passive wrist extension is accompanied by digital flexion, is often unreliable in assessing zone I injuries.

I suggest adding this test to the armamentarium when faced with assessment for possible flexor tendon injury.

Table 1. Flexor injuries

<table>
<thead>
<tr>
<th>Site of injury</th>
<th>Number of patients</th>
<th>Volar plate intact</th>
<th>Volar plate damaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zone I</td>
<td>2</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Zone II</td>
<td>7</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>