Certainly no-one interested in occupational mortality should fail to read this decennial supplement, at least in part. The serious epidemiologist will also want to have access to the fiches. However, it is to be hoped that anyone using the wealth of material contained in the supplement and the fiches will exercise the same caution as Dr John Fox and avoid the eye-catching and sometimes misleading headline. Dr Fox, according to the Registrar General’s preface, ‘did the lion’s share of the work’ in preparing the commentary and analysis—truly a remarkable performance.

**ANN PETRIE**


Coroners were first appointed in England in 1194. Their main responsibility was financial rather than judicial: convicted felons had to forfeit to the king their goods and chattels, worth being determined by the coroner who also imposed fines on the community for failing to maintain law and order. At first coroners were not paid and their status declined because responsible persons refused to accept a position that was time-consuming and unpaid. Extortion was widespread with coroners demanding payment before calling inquests. In 1751 an Act was passed to give proper payments: 20 shillings for each inquest plus 9d a mile travelled. The act also made it possible to remove a person from this life-time appointment for misdemeanour or neglect of duty. Since coroners had to keep records of inquests of those who had died from other than natural causes, in prison, suddenly or in suspicious circumstances, they unknowingly assembled valuable data. The Births and Deaths Registration Act of 1836 regularised the reporting of deaths and reformed coroners’ duties. It became much more difficult to conceal ‘homicide and it revealed occupational causes of death’.

Dr Thomas Forbes, Professor of Anatomy at Yale University, has given a fascinating history of the coroner and the inquest. He has analysed the surviving records of over 6000 inquests conducted by the coroners for the City of London and Southwark, from 1788–1829. He gives an account of the development of the coroner’s system to the modern ideal from a time when it was at its nadir, with the unqualified coroner, open hostility with the justices of the peace, lack of regulation for disposal of the dead body and lack of adequate medical evidence. There was a gradual but conspicuous increase in the proportion of post-mortem examinations done at inquests. It rose from less than 1% at the beginning of the period to about 20% at the end. This was probably due to a growing interest among the medical profession in pathology and dissection of the human body. Inquests on the deaths of hospital patients in the City and Southwark Hospitals, which included St Bartholomew’s, St Thomas’s and Guy’s, increased 15-fold in 25 years.

During this time when London’s population doubled, deaths from burns increased more than seven times, fatal falls tripled, drownings remained at the same level, while deaths involving vehicles and horses kept pace with the population growth. All other fatal accidents tripled, an increase in risk which probably reflects the impact of mechanisation. Out of 3316 accidental deaths, 944 were classified as occupational. The commonest cause was falls, particularly from ladders and scaffolds. Between 1825 and 1831 about 800 men were employed building London Bridge; 40 of them are said to have lost their lives, mostly by falls. Accidents to chimney sweeps are a sad reminder of the child abuse of those times. Much of this work was done by young boys chosen for their small size and deliberately malnourished, it is said, to retard their growth. If they survived suffocation or injury they might live to develop pulmonary tuberculosis or scrotal cancer. Alcoholic intoxication and infection were common contributory causes of death. Drunkenness seemed frequently to have been the cause of falls from ships and barges, and infection repeatedly caused death after recovery from the original injury.

There are other sections which deal with suicides, homicides and deaths from illness. All these and particularly the historical aspects of the coroners’ work will interest many people. It is, however, the section on occupational accidents which will absorb practitioners and students of occupational health.

**RICHARD SCHILLING**


This report is similar to the Swedish report, *Cadmium in the Environment* (2nd edition) and covers the complete story of cadmium from its chemical and physical properties, its natural occurrence, concentrations in the environment, metabolism, toxicological effects, and some existing guides and standards for environmental levels.

The last two chapters are devoted to needs for further research and a tentative proposal for a no-effect level for long-term exposure to cadmium. These two chapters are the most interesting in that they provide a summary of world thinking concerning problems of cadmium in the environment, and even though this is primarily a European study (and it is obvious from the format that this is mainly the work of Professor R. Lauwers), the philosophy follows the international line.

The needs for further research include some very interesting subjects, but apart from the cadmium metabolism section the toxicity studies suggested will require very long and patient surveys throughout the world. Because of the relatively small numbers of people who are exposed to cadmium compounds, it is most important that the practising occupational health doctor should take part in these surveys. Most of the work which has so far been commented on is basically talking about current exposure levels in the general population, and although a lot of information is coming from Japan and Italy itai-itai disease, there is still a considerable amount of uncertainty about the result of these surveys. It is essential that exposure risk criteria are evaluated for people with known high exposure to the various cadmium compounds, and it is only in the study of those at work that this could be evaluated by means of retrospective and prospective studies.

The increasing use of sensitive biological tests makes it imperative that there should be standardisation of methodology, and potentially high exposure groups in the general population should certainly be investigated.

One area which is constantly neglected is mortality studies in people with long-term exposure to cadmium. It is extremely difficult to argue that excess β2 microglobulin in the urine, for example, is not a positive sign of kidney damage. However, it is well known that there are many workers who have had this type of proteinuria for 20 years or more and seem to have a normal life expectancy.