British Association of Perinatal Medicine
Response to Consultation feedback

Document Title: **The Prevention, Assesssment and Management of in-Hospital Newborn Falls and Drops**
Closing date: **4 March 2020**

Page number/ heading / general comments	Line number/ 'general' for comments	Comments Please insert each new comment in a new row.	BAPM Response
Name of person or group providing feedback: Dr Janet Berrington Consultant neonatal paediatrician Newcastle Neonatal Services Newcastle upon Tyne Hospitals NHS Foundation Trust Royal Victoria Infirmary Newcastle NE1 4LP			
General	General	I cannot see mention of consideration of CT scanning where there are safeguarding concerns – we suggest CT scanning if this is the case to ensure that if there is re-presentation after discharge it is clear that the findings do not (or do) relate to an episode of being dropped in hospital	Thank you for your time to review and comments. We eschewed CT for all babies with in-hospital fall with safeguarding concerns to avert unnecessary radiation in babies where there was not a therapeutic or diagnostic indication. We discussed safeguarding at every step and suspicion of non-accidental injury is an absolute indication of CT scanning (Table 3 – suspicion of non-accidental injury). However, the team need to gather good history and explore family history (Appendix -2 sample proforma for history and assessment) and discuss with the consultant as soon as possible to discuss the management plan and place of safety (Page 12; Care pathway- detailed assessment section 2. (ii) (d). In section 4- (i). (b) & (iii). (b) discharge and follow up- we have further highlighted the importance and possible delay discharge if the team have any safeguarding concerns. This

			is to ensure the team have adequate time to obtain all relevant information and discuss with the safeguarding team. Clear documentation and degree of concern in the red book and effective communication amongst the team, as highlighted in section 4 would provide a safety net for babies representing to A&E.
Name of person or group providing feedback: Sharon Ward Deputy Head of Safeguarding Portsmouth Hospitals NHS Trust Corporate Services Division, Safeguarding Service, First Floor Southwick Lodge, Queen Alexandra Hospital, Cosham, Portsmouth, PO6 3LY. Email: Please find attached my comments regarding the Baby Falls framework you have sent out for consultation. I have also attached our local bruising protocol for your reference. Sadly, whilst few and far between, physical abuse of newborn babies does occur and this can happen in hospital as well as at home and can be perpetrated by staff as well as parents. Clearly the vast majority of newborn baby drops/falls are accidental, but we need to have a framework that ensures this isn't just assumed but ascertain through robust assessment of risk.			
General	General	The framework does not make clear enough the safeguarding actions required in the event of a baby drop/fall. All newborn babies are not independently mobile and therefore any injuries are either caused accidentally or non accidentally. It is not safe practice to just assume that an injury has been sustained accidentally because a parent reports a drop / fall, the only time we can take this as being fact is if a member of staff has witnessed the drop/fall. Likewise, if the drop / fall occurred while the baby was being held / cared for by a member of staff we cannot assume it was an accident UNLESS a parent or other member of staff has witnessed the incident. In all other situations part of the clinical assessment must include consideration of whether the mechanism described is consistent with the presenting injuries, whether the 'story' has been consistent and the wider social situation, safeguarding risk factors and other information known by other agencies including Children's	Thank you for your time to review and forwarding comments. We have amended the document on account of the comment received and added section 2 care pathway – detailed assessment (i) (b) on page 12. The majority of drops are unwitnessed with limited history available to explain mechanism of injury. The vast majority are accidental. However clinical staff need to be alert to the possibility of non-accidental injury or an element of neglect in accidental drops. As such attention ot be given to ensuring consistency of history, consistency between injury and the proposed mechanism of injury, any other associated injuries, and the wider social situation, safeguarding risk factors and information known by other agencies.

		Services. Many areas will have 'Bruising Protocols' which should be followed.	
Name of person or group providing feedback: Dr Allison Grove Consultant Paediatrician / Associate Medical Director Mid Yorkshire Hospitals NHS Trust			
General	General	My major issue is that this guideline is being developed far too late. The patient safety alert (PSA) re dropped babies required all trusts to have a guideline in place by 8th November 2019. The PSA stated that BAPM would be producing guidance to support trusts in developing their own guidance. Because the BAPM guidance is only now being developed we as a trust spent many hours in having to develop our own guideline from scratch in order that we as a trust were complaint with the NHSE deadline. This will have had to be replicated across all other trusts. A massive amount of clinicians time nationally could have been saved if the BAPM guidance had been published in time to allow trusts to meet the PSA deadline.	We sincerely apologise for the inconvenience caused by this delay and appreciate your hard work and effort to be NHSE compliant. The delay arose from ensuring the working group had representation and input from all relevant parties.
General	General	The content of the guideline is fine – very similar to the guideline we have developed in our own trust by the required deadline of 8th November 2019	