Improving Section 47 reports by the Paediatric Department on the Isle of Wight

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1. Introduction

A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. Findings from the enquiry are documented in an official Section 47 (S.47) report. Initiated in every case of suspected child abuse, the Section 47 process has tremendous effects on the child and the family along with significant medico-legal implications.

2. Objectives

- Assess the compliance of our Trust's (St. Mary's Hospital) reports with the guidelines of the Royal College of Paediatrics and Child Health (RCPCH) Child Protection Companion.
- Highlight key omissions or deviations from the recommendations, if any, and take steps to address these for improvement.

3. Methods

- The study began as a retrospective study and a compliance audit of the S.47 reports submitted from the 1 January to 31 May 2019. Over this period, the S.47 process was activated for 17 cases.
- We followed a multidisciplinary approach, involving the Police and Children's Social Care (CSC) who mentioned what they would look out for in a S.47 report.
- Based on the audit findings, some key information was added to the already existing unit safeguarding proforma including:
  i. Consent for examination
  ii. Consent for information sharing
  iii. Chaperone present
  iv. Parental responsibility
  v. On child protection plan or not
  vi. Parental health history (CSC requirement)
  vii. Documented consultant opinion (police requirement)
  viii. Preliminary paediatric opinion form.
- The use of the new proforma for subsequent S.47 cases commenced on 1 November 2019 and post-change data was obtained until 31 January 2020 with a total of nine S.47 cases activated. Figure 1 shows comparison between pre- and post-change findings.

4. Improvement

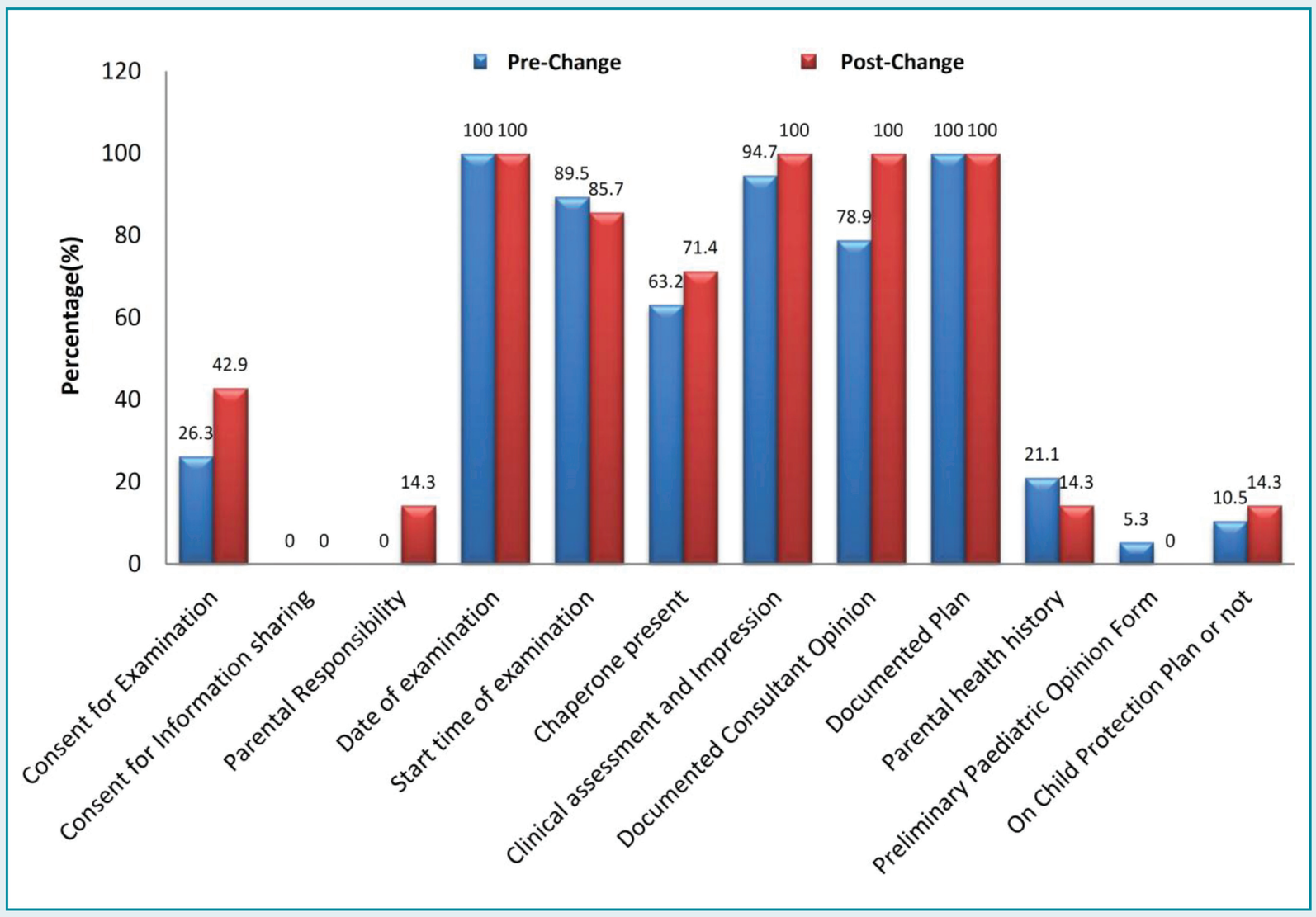

Figure 1: Bar chart showing some important information required in S.47 reports and the percentage of reports that had them documented (pre-change and post-change).

5. Lessons

Key personal learning points were:

- In a multidisciplinary team setting, improvement of the quality of service delivery requires effective communication and setting a common goal
- To achieve the desired change in a team, each individual has to be encouraged and carried along
- Help can be obtained from clinical and non-clinical colleagues, if kindly requested
- Patience and persistence are the prerequisites for progress

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