10) **We recommend** that the Department of Health should take steps to ensure that its guide, "Welfare of Children and Young People in Hospital", is more closely observed (para 5.8.8).

11) **We recommend** that in the event of failure of an alarm on monitoring equipment, an untoward incident report should be completed and the equipment serviced before it is used again (para 5.11.6).

12) **We recommend** that reports of serious untoward incidents to District and Regional Health Authorities should be made in writing and through a single channel which is known to all involved (para 5.14.12).

13) The foregoing recommendations are aimed at the tightening of procedures to safeguard children in hospital. But no measures can afford complete protection against a determined miscreant. **The main lesson from our Inquiry and our principal recommendation is that the Grantham disaster should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events.**