Results 3% of all 1289 child protection referrals seen in the 12 month period were penetrative CSA cases. 60% of cases were female and 76% were under 13 years of age. 23% of cases had another child aged 11 to 16 years as the perpetrator and 89% of these were non-relations. 35% had previous child protection medicals performed within 3 months to 8 years. 20% (7 cases) were forensic medical examinations and 1 of these was deemed by the author to have been seen out of the appropriate forensic sampling window. 40% of the forensic cases where emergency contraception was indicated as part of the medical care were seen more than 5 days after the incident. We performed STI screening on 82% of cases as per local protocol and of those tested there was a 6% STI rate

Conclusions A large number of penetrative CSA cases are seen yearly, many are re-referrals and a significant number are perpetrated by other children. Forensic medical examinations were indicated in 20% of cases however these often fell outside the window for timely emergency contraception and appropriate forensic sampling. A significant minority of cases seen also had an STI when screened.

We suggest particular attention should be given to timing of medical examinations to optimise not only forensic sampling but also medical care and emphasise the importance of appropriate STI screening.

G219(P) AN ASSESSMENT OF THE QUALITY OF CHILD PROTECTION REPORTS CREATED AT A SINGLE NHS TRUST

doi:10.1136/archdischild-2013-304107.231

ND Ruth, A Hughes. *Paediatrics, Sandwell and West Birmingham NHS Foundation Trust, Birmingham, UK*

Aim There have been a number of high profile cases around safeguarding. To compare CP medical reports to current gold standard and identify what needs improving, so that CP medical reports offer a clear opinion of the nature of the injuries identified. The aim of this study was to identify the gold standard for compiling safeguarding reports, and to highlight any shortfalls compared to this locally agreed standard, so that these can be improved upon for future reports.

Methods 329 child protection reports were collected over an 18-month period at a single NHS trust. Key areas assessed included documentation of: consent, date/time, any past medical/social history, growth parameters, injuries seen and location, conversations, referrals and management plans, and whether a clear opinion was given.

Results Written or verbal consent was documented in only 42% of cases. Date was documented in 97% and time in 24 hour clock in 85% of cases respectively. Reason for referral was clearly documented in 79% of cases. A background to the case was including past medical history, development, social history was poorly documented (fig. 1). Cleanliness and general appearance was commented upon in 55% of cases (fig. 2). Opinions, conversations, investigations and referrals had variable reporting (fig. 3) with investigations in 152/329 (46%), treatment in 143/329 (43%), referrals 205/329 (62%) and conversations documented in 247/329 (75%) cases.

Conclusion Injuries were documented in 270/329 (82%) cases. An interpretation of the injuries was given in 280/329 (85%) cases, with an opinion on whether these may be consistent with the mechanism of proposed injury in 260/329 (79%). Even though a good proportion of injuries were documented correctly and interpretation was likewise reported in >80% of cases, this should in fact be reported in all cases and therefore although good, there is still room for improvement.

The major area of disparity was in the consent documentation which was poor. The recommendation of the study was that clear consent must always be sought and documented (including verbal consent) every time. The type and location of injury should likewise

be clearly documented as well as any opinion given as to the nature of these injuries, so that there can be no ambiguity and therefore a clear judgement can be made.

G220(P) PATTERNS AND MANAGEMENT OF FRACTURES IN CHILDREN UNDER 18 MONTHS IN A GENERAL HOSPITAL

doi:10.1136/archdischild-2013-304107.232

S Gaddam Bhoomaiah, A Salim, H Grindulis. *Sandwell & West Birmingham NHS Trust, Birmingham, UK*

Background The type of fracture alone cannot ascertain associated safeguarding/child protection issues, and it is therefore important to carefully assess and document each case. It is expected that all fractures under 18 months are discussed with the paediatric team in view of the raised likelihood of abusive cause in this age group.

Aims To assess whether fractures in children less than 18 months of age presenting to the emergency department (ED) are discussed with a consultant paediatrician; and to review documentation and which team(s) managed fractures in this age group.

Methods Children under 18 months of age having skeletal x-rays between September 2010–11 were identified from the Radiology IT system. For those showing a fracture information was gathered from clinical IT systems, ED notes, and hospital case notes. The type of fracture, mechanism of injury, and time to presentation were reviewed. It was determined whether the patient was discussed with a consultant paediatrician; and whether management involved the paediatric team or was solely by the ED or orthopaedic team.

Results 209 x-ray reports (in 162 children) were reviewed and 55 fractures identified. Three were excluded as ED notes not found. Age range was: 0–6 months 7 fractures; 6–12 months 40 and 12–18 months 8. See table 1 for fracture types. The time interval between injury and presentation was recorded in 27(51%) - (74% <24 hours vs. 26% >24 hours). The mechanism of injury was noted in 36(70%). 21(40%) were discussed with a consultant paediatrician of whom 2 had abusive fractures. 17(33%) were referred to orthopaedics alone; and 14(27%) were managed only by ED.

Conclusions Documentation and discussion with paediatrician was inadequate. Clavicular fracture was most frequent and finger crush fractures quite common. It was not possible to judge accurately which cases were checked for social services involvement by ED. Further awareness-raising with ED staff followed by re-audit is planned.

Abstract G220 Table 1 Types of fracture in children under 18 months

Clavicle 11	Femur 5
Radius 10	Tibia 7
Ulna 4	Tibia + fibula 2
Radius + ulna 1	Metatarsal 1
Humerus 6	Skull 1
Finger 7	

G221(P) AUDIT OF CSA (CHILD SEXUAL ABUSE) SERVICE

doi:10.1136/archdischild-2013-304107.233

S Gopinathan. *Community Paediatrics, Southwest Essex, Basildon, UK*

Background In our trust the current CSA service was established in 2010. We run weekly clinics jointly done by two experienced community paediatricians. On a monthly basis we hold a peer review meeting where cases are discussed including photographs and reports.

Details To determine whether the referral criteria are followed and to analyse the referrals received since January 2010.

The referral criteria is as follows:

- if there is allegation of CSA of more than 72 hours
- recurrent genito-urinary symptoms with concern of CSA
- disturbed behaviour suggestive of CSA
- history of worrying contact with sexual offender suggestive of CSA

Evaluation Retrospective audit of referrals received over a period of two years from January 2010- December 2011 by reviewing the records.

Total of 32 referrals were received. Out of the 32 referrals, 20 (16 girls and 4 boys) were in 2010 and 12 were (8 girls and 4 boys) were in 2011.

Age group

Abstract G221(P) Table 1

	2010	2011
Less than 1 year	1 (5%)	1 (8.3%)
1–5 years	4 (20%)	6 (50%)
5–10 years	11(55%)	2 (16.6%)
10–13 years	2 (10%)	1 (8.3%)
Over 13 years	2 (10%)	2 (16.6%)

Source of referrals In 2010, 14 (70%) referrals came from social services, 3 (15%) from Police, 2 (10%) from GP and 1 (5%) child from the local hospital.

In 2011, 8 referrals were received (66.6%) from Social Services and 4 (33.3%) from Police.

Reasons for referral Disclosure by the child 12/32 (37.5%), Vaginal discharge/bleeding 7/32(21.8%), Behavioural changes 3/32(9.3%), Genital warts 2/32(6.2%), Witnessed by others 1/32(3.1%), Genital injury 1/32(3.1%), Parent downloading indecent images of children 2/32(6.2%). The history was vague in 3/32 children (9.3%).

Conclusion

- Majority of cases met the referral criteria.
- 1–10 years of age were the largest group.
- Quarter of the children was boys.
- Majority of referrals came from social services.
- The most common type of referral was disclosure by the child.
- The referral criteria were revised in 2011 which explained the reason for drop in referrals in 2011.
- The opening of SARC in 2011 has helped to provide comprehensive package of care.

G222(P) A REVIEW OF SKELETAL SURVEYS 2008–2012 AT KCH – A SAFEGUARDING PERSPECTIVE

doi:10.1136/archdischild-2013-304107.234

¹S Moss, ²S Soni, ²O Akindolie. ¹Paediatric Department, Kings College Hospital NHS Foundation Trust, London, UK; ²General Paediatrics, Kings College Hospital NHS Foundation Trust, London, UK,

Aims We compared the skeletal surveys done at King's College Hospital (KCH) to the guidelines of the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Radiologists (RCR). We reviewed the skeletal surveys performed in children for suspected Non-Accidental Injury (NAI). We included both radiological and social conditions for each patient.

Methods The KCH radiology department maintains a list of all skeletal surveys performed by it. We reviewed the cases of children aged between 0 and 16 yrs who had skeletal surveys between 2008 and 2012 using information held on the electronic patient record and PACS.

Results 100 skeletal surveys were performed on children aged between 0 and 16yrs between 2008 and 2012. 81 of these were for investigation of possible NAI, of which 37% proved positive for

NAI. A more detailed look at these positive cases revealed that 81% of these were aged less than 1yr and 6% were greater than 2 years old. 88% of surveys completed all the recommended x-ray views but only 49% of children had a follow-up chest x-ray as recommended. 81% were carried out while the child was an inpatient. The majority of children were not previously known to social services, signified by the fact that only 19% were on a child protection plan. Since KCH is a tertiary referral centre many children came from outside of the Lambeth and Southwark boroughs (44%).

Conclusions KCH performs well against the standards set by the RCPCH and the RCR in performing skeletal surveys. The numbers stated above are comparable with other centres. KCH may see slightly higher numbers of children investigated for NAI, but this is due to the fact that it is a tertiary referral centre. The surrounding boroughs of Lambeth and Southwark are densely populated areas with a relatively young population compared to national averages. The population is multi-ethnic and diverse with high unemployment and poverty. These are all risk factors for NAI and the safeguarding team at KCH have to be especially alert to the possibility of NAI.

G223(P) A COMMUNITY-BASED STUDY ON THE ACCEPTABILITY, EFFICACY AND SAFETY OF BUCCAL MIDAZOLAM IN CHILDREN WITH EPILEPSY

doi:10.1136/archdischild-2013-304107.235

A Khan, A Baheerathan, G Setty, N Hussain. *Paediatric Neurology, Leicester Royal Infirmary, Leicester, UK*

Background Convulsive status epilepticus is the most common paediatric neurological medical emergency and confers a high degree of morbidity and mortality. Early treatment before admission to hospital is pivotal and thus, an efficacious rescue therapy that can be administered easily, acceptably and safely is paramount. In the paediatric population, rectal diazepam has often been regarded as the first-line therapy; it has shown to be efficacious (inducing remission in 60–80% of patients), however, issues persist regarding its safety, especially the risks of respiratory depression and seizure recurrence. Buccal midazolam has emerged as an efficacious alternative and its use as a rescue therapy in status epilepticus is widely increasing; despite this, little is known about the effectiveness and side-effect profile of buccal midazolam from the perspective of carers.

Aims To identify the efficacy, safety and acceptability of buccal midazolam as a rescue therapy in children with prolonged epileptic seizures from the perspective of carers.

Methods Community-based face-to-face interviews (existing research had utilised telephone interviews) of 25 patients under the care of our department was undertaken to evaluate the effectiveness, adverse effect profile and acceptability of buccal midazolam as a rescue treatment for prolonged seizures. All children were administered Epistatus, a proprietary oral solution (10 mg/ml).

Results The doses administered as rescue therapy varied from 2.5 to 10 mg. We evaluated therapeutic success, time taken for cessation of seizures and necessity for emergency department attendance. We also looked at the development of side-effects, namely respiratory depression and sedation following its administration. 96% of families who had used buccal midazolam found that it usually effective in seizure termination and that it prevented hospital admission in 65% of cases. 100% of our patient cohort who had used both buccal midazolam and rectal diazepam preferred the former due to its easiness of administration, social-acceptability and its lesser sedative effect.

Conclusion Our study indicates that buccal midazolam is an efficacious alternative to rectal diazepam and that its use is preferred by patients.

Please note: Although our current sample size is 32, we plan to increase this to 50 by the time of the conference.