

Methods In May 2014 a new policy was introduced within the hospital where every woman with FGM, who gave birth to a female infant, was referred to social care. This policy arose from a recommendation by the local safeguarding children board. Health care professionals were asked to complete a screening questionnaire with the mother and attach the answers to the referral. The questionnaire asked details about maternal FGM, thoughts about her child having FGM and the potential for family pressure. Over a five month period (May to September), all the social care referrals were analysed to assess the outcome of the referral and if the questionnaire helped to stratify the degree of risk of FGM to the female infant.

Results In the time period studied 163 women who attended antenatal booking reported that they had undergone FGM. Of those who delivered in the five month study period, 32 went on to give birth to a female child. The immediate outcomes of these 32 cases were analysed and categorised into high, medium and low risk. Of those who were high risk, two were allocated to a senior social care practitioner for formal assessment, two cases are on-going formal assessment and three were allocated to early help. Of the medium risk, six cases were referred to a multi-agency service and in three cases the family was offered further support through the charity sector. In the low risk category, 14 cases required no further intervention (in one case the screening questions themselves acted as an adequate assessment). One case needed continued support by social care due to disability of the child and in one case the outcome was not known.

Conclusion The questionnaire formalised the referral process, identified infants at high risk and also helped to stratify risk into low, medium and high. It also indicated the demographics at highest risk. The questionnaire also has potential as a primary prevention measure in itself.

G49

SKELTAL SURVEYS IN PATIENTS <2 YO PRESENTING WITH FRACTURES TO THE ED DEPARTMENT: WHEN ARE THEY APPROPRIATE?

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Aims To audit current practice and develop guidelines on the ordering of skeletal surveys in patients <2 yo presenting with fractures to our ED department

Methods We used the guideline published in *Paediatrics*: "Development of Guidelines for Skeletal Survey in Young Children with Fractures".¹ Using our online server we reviewed data over two years (2012–2013). Patients <24 months and any patient presenting with a fracture presenting to ED were included. In accordance with the guideline, data audited included age (0–11 ms, 12–23 ms), developmental status (ambulatory v non-ambulatory), time from fracture to presentation, history and mechanism of injury, pertinent features on examination, existent co-morbidities, radiological characteristics and age of fracture, decision to skeletal survey and time from fracture to skeletal survey.

Results 59 patients were identified over the two year period (range 22 days–23 months). 20.3% (n = 12) were between 0–11 ms, 79.7% (n = 47) were between 12–23 ms. 1 patient (1.7%) aged 9 ms had a skeletal survey. If the above guideline had been applied, 40.7% of this patient cohort would have warranted a skeletal survey, and 75% (n = 9) of our 0–11 agegroup and

31.9% (n = 15) of our 12–23 agegroup would have qualified for a skeletal survey.

Conclusion In a busy ED department with short physician-patient interaction a systematic approach to child protection is of paramount importance. This data suggests that our centre is under-utilising skeletal surveys in the management of children under the age of 2 presenting with fractures to our ED department. Significant cultural differences may impact on the relevance of this guideline for our patient population. We are developing a new protocol to help ED doctors decide when a skeletal survey is appropriate in vulnerable children.

REFERENCE

- 1 Wood JN, Fakeye O, Feudtner C, et al. Development of guidelines for skeletal survey in young children with fractures. *Pediatrics*. Originally published online June 16 2014, DOI: 10.1542/peds.2013-3242.

G50(P)

SIBLING CHILD PROTECTION (CP) MEDICALS ARE CURRENTLY CONDUCTED ON AN ADHOC BASIS: THE NEED FOR NATIONAL MINIMUM STANDARDS FOR IDENTIFICATION AND EXAMINATION OF THIS VULNERABLE GROUP

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Background There are currently no minimum national standards for conducting sibling CP medicals and few published studies show little consensus amongst healthcare professionals and social services in conducting these medicals.

Aims Collation of sibling CP medical information from senior safeguarding clinicians in our region and examination of the child protection database of our NHS Trust with the aim of formulating a local sibling CP medical protocol.

Methods First survey: online Survey Monkey was sent out to 40 safeguarding doctors and nurses in our region from Dec 2013–Feb 2014.

Second survey: analysis of records of all CP referrals and medicals conducted in 2010 including handwritten CP medical proforma and final typed medical reports completed by Paediatricians in our NHS Trust.

Results 25% responded to our Survey Monkey. Majority of respondents said they conducted sibling CP medicals in their organisations. Most respondents (80%) had no protocol to guide their decisions and commented that medicals were normally done on an adhoc basis.

In the Trust survey, a total of 178 CP medicals were conducted in 2010. We identified 2 pathways of referrals. All siblings (100) of index cases referred as a family unit (37 families) had a CP medical (100%). 78 children were referred as individual index cases. 48/78 children referred by Social Services as individuals were identified to have siblings. 26/48 index cases who had siblings were identified as having CP concerns. 8/26 index cases were removed from their homes. There was no record (0%) of sibling medicals conducted in any of the 48 index cases with siblings including index cases with CP concerns.

Conclusion There is very little consensus on performing CP medicals on siblings of index cases in our region and local Trust. Siblings of index cases referred as individuals did not have a medical even when there were significant CP concerns. Following the 2 surveys, a CP sibling medical protocol to guide local

Paediatrician's decision regarding identifying/conducting medicals has been proposed.

G51(P) A REVIEW OF CHILD SEXUAL ABUSE (CSA) REPORTS

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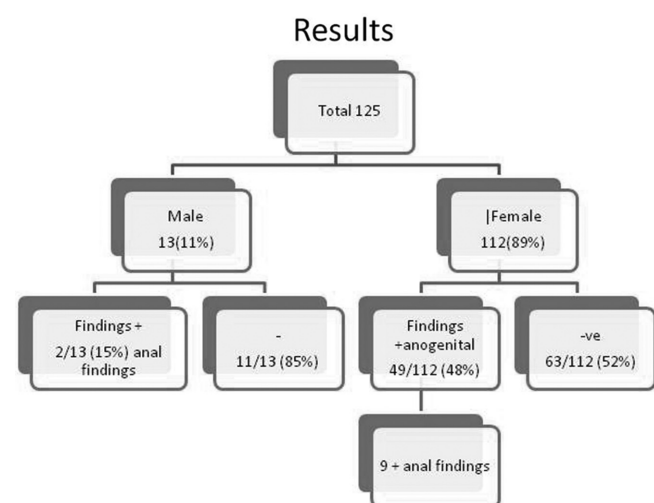
Background Few areas of paediatrics have expanded so rapidly in clinical importance as that of sexual abuse of children. What Kempe called a "hidden paediatric problem"¹ in 1977 is certainly less hidden at present. The NSPCC statistics April 2014 showed 1 in 20 children have been sexually abused. 5% of all the children on child protection registers or the subject of child protection plans in the UK were under a category of sexual abuse. Childhood sexual abuse has been correlated with long term morbidities like mental health problems and sexual and relationship problems. So this is a significant public health problem.

Aim We aimed to gain more knowledge on the CSA (child sexual abuse) examination findings in particular the anal findings, the demographics and to find out the prevalence of significant positive findings.

Methodology We carried out a retrospective analysis of CSA reports of children who underwent CSA examination during the 2 year period – April 2011 to April 2013. The electronic reports were accessed following formal permission from the trust.

Findings Majority of the children who underwent CSA examination are females (Figure 1). Only a small proportion of boys were examined. Most of the children were arranged to have the examination following disclosure (Table 1). Nearly half of the female children were noted to have some significant findings; however some of them were conclusive of sexual activity rather than abuse. Only 8.8% of children had positive anal findings and 54% had consistent history.

Conclusion Sexual abuse presents in many ways and because children who are sexually abused generally are coerced into secrecy, a high level of suspicion may be required to recognise the problem. Only a small proportion of children were noted to have clinical anal findings, so a detailed history taking is vital.



Abstract G51(P) Figure 1 Results of examination following disclosure

Abstract G51(P) Table 1 Reason for CSA examination

Disclosure	102
Sibling disclosure	7
3rd party concerns	4
Sexualized behaviour	2
Porn website pictures	2
Hitting on bottom	1
Recurrent Vulvovaginitis	2
Genital Bleeding	1
Anal warts	2
Extreme distress during nappy changes	2

G52(P) EVALUATING A SAFEGUARDING PEER REVIEW AND REFLECTIVE SUPERVISION INTERVENTION: EXPLORING PAEDIATRICIANS' PARTICIPATION AND LEARNING

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Aims To establish regular peer review and reflective supervision for paediatricians at both sites of an NHS Trust for a six month period and evaluate participation and learning.

Methods An action research methodology was chosen. Morrison's $4 \times 4 \times 4$ reflective supervision model was selected because of its focus of improving safeguarding outcomes for children. New documentary output was developed for peer review sessions. To support participation, peer review and supervision sessions were scheduled during monthly clinical governance half-days. Attendance at clinical governance sessions is expected for all available paediatricians. Participation in the evaluation of learning was optional. There are 21 paediatricians permanently employed by the Trust. Their participation, any resultant learning and impact was to be explored through examination of documentary outputs from the sessions including attendance registers and from semi-structured interviews. This service evaluation project was registered with the NHS organisation. The evaluation of learning has approval from a university ethics committee.

Results Experienced supervisors were secured and a steering group established. Six sessions were planned at each site beginning with supervisee training for reflective supervision. Then there was to be alternating sessions of reflective supervision or peer review at each site. For the site with 13 paediatricians, six (6/13, 46.2%) were present for training. Of the subsequent five sessions, only one session has taken place. There were four attendees (4/13, 30.8%) at the reflective supervision session, only two of whom had attended the training. Four of the sessions did not take place. For the site with 8 paediatricians, three (3/8, 37.5%) attended training and none of the five planned sessions happened. Of the nine missed sessions, analysis indicates that unavailability of the Named Doctors for Child Protection accounted for four missed sessions, unavailability of other paediatricians for an additional four and an administrative error for one. The details of the barriers to participation will be presented.

Conclusions Scheduling peer review and reflective supervision during clinical governance half-days did not secure