requested from both sites in the trust. The standards to compare were identified and information collected in a proforma. This information was later summarised using Excel spreadsheet.

Results 31 case-notes where skeletal survey (SS) was performed over these two periods were reviewed, of these 17 cases were suspected physical abuse, 12 were for unexpected child death/SUDI and 2 were for genetic reasons.

- 17/31 skeletal surveys studied were for presumed NAI, –4/17 before (2007–08); and 13/17 (2009–10) after 2008 guidelines – 2/14 for genetic conditions, 12/14 for child death or SUDI
- Of 17/31 with presumed NAI, presentation included – Bruises 10/17 – Fracture 3/17 – Scalp swelling 4/17 (1 had bruising and scalp swelling) – Occult – suspected shaken baby syndrome
- Communication between paediatrician and carers poorly documented – Concerns 1/3rd (pre) and 2/3rd cases (post) – Explanation of imaging 0/3 (pre) and 1–3/12 (post) – Consent for imaging 0 (pre) and 0 (post)
- Communication between Paediatricians and Radiologists poorly documented, only 2–3/17 cases
- Good performance with respect to – Timing (< 1 day), 3/4 (pre) and 8/13 (post) – Completeness of Skeletal Survey 4/4 (pre) and 12/13 (post) – Verbal report (< 1 day) 4/4 (pre) and 12/13 (post) – Final report (<1 day) 2/4 (pre) and 11/13 (post)
- Report, scope for improvement in –Age of injury 2/2 (pre) and 1/3 (post) – Bone density 3/4 pre) and 2/13 (post) – Differential diagnosis 1/2 (pre) and 4/7 (post)
- Additional information from skeletal survey 2/17, (~ 12%)

Summary The study revealed good performance in completing and reporting skeletal survey but documentation of concerns, explaining pathway, sharing concerns with radiologist and some aspects of reporting were not consistent.

G228(P) CHALLENGES OF REFERRING CHILDREN TO SOCIAL CARE FOR REFUGEE COMMUNITY ORGANISATIONS

doi:10.1136/archdischild-2013-304107.240

[1]J Thomas, [2]C Hands. *[1]Paediatrics, Newham University Hospital, London, UK; [2]Neonates, Imperial College Healthcare, London, UK*

Aims To describe the reasons why refugee community organisations make safeguarding referrals to children's social care. To describe the actions taken by children's social care after such referrals have been made and their effects.

Methods All safeguarding referrals made by one London refugee community organisation between December 2002 and December 2012 were reviewed. The categories of abuse under which each referral was made, other relevant factors and the outcomes of the referrals were recorded.

Results

Abstract G228(P) Table 1

Category	
Neglect	4
Neglect + physical abuse	4
Neglect + physical abuse + emotional abuse	3
Neglect + emotional abuse	2
Physical abuse	5
Physical abuse + emotional abuse	4
Emotional abuse	3
Sexual abuse	1
No category stated	1

Abstract G228(P) Table 2

Outcome	
Assessment done	21
Result	
No action	18
Child in need	4
Child protection plan	4
Other intervention	1
Effect on relationship with organisation	
Continued as before	17
Continued after a break	5
Permanently broken	5

Conclusions Refugee community organisations frequently make referrals to children's social care. The referral and social care assessment can lead to the breakdown of the relationship between the organisation and the family concerned, leading to a loss of support for the child. Enhanced forums for discussing the cases of vulnerable children with social care outside of making a formal referral are needed to improve the coordination of services.

British Society for Paediatric and Adolescent Rheumatology

G229 A, B, C, DON'T EVER FORGET THE JOINTS! – A YORKSHIRE PAEDIATRIC RHEUMATOLOGY NETWORK AUDIT

doi:10.1136/archdischild-2013-304107.241

[1]WM Abusrewil, [1]A Whiteley, [2]A McMahon, [2]M Al-Obaidi. *[1]Paediatrics, Leeds Teaching Hospitals Trust, Leeds, UK; [2]Paediatric Rheumatology, Sheffield Children's Hospital, Sheffield, UK*

Aims To assess if the musculoskeletal (MSK) examination was being performed, in eight paediatric centres across Yorkshire, when the clinical situation would suggest it was warranted, using the pGALS examination tool [1]

Methods 397 case notes were randomly collected and reviewed retrospectively for patients who had presented to hospital between August-November 2012. Each centre assessed approximately 50 sets of patient's notes

The admission notes were reviewed to find out whether a MSK examination had been documented by the doctors on the initial assessment and then the first and second reviews, if there were triggers or red flags for the examination.[1]

Evidence of documentation of the systemic clinical examinations performed and pertinent clinical variables, including times of admission and the grade of the doctors reviewing patients, were noted.

The information was collected on excel spreadsheets at source hospitals and collated by the audit team to investigate the trends across Yorkshire.

Results 35% of the 397 admissions had a trigger for a MSK examination.

26% of the 397 admissions had a red flag for a MSK examination.

Not a single patient who needed a MSK examination on initial assessment or first review had a full MSK examination documented. In comparison 80% of patients routinely had a respiratory and cardiovascular examinations documented on initial assessment.

Only 1 out of 105 patients who had a red flag for a MSK examination had a complete examination documented.

Conclusions In 2004 the musculoskeletal examination was shown to be poorly documented.[2] This audit shows that the musculoskeletal