

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

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

<sup>1</sup>S Deepak, <sup>2</sup>C Teh, <sup>2</sup>L Adamson. <sup>1</sup>Paediatrics, East Midlands Paediatric Trainee, Nottingham, UK; <sup>2</sup>Community Paediatrics, Derbyshire Health Care NHS Foundation Trust, Derby, UK

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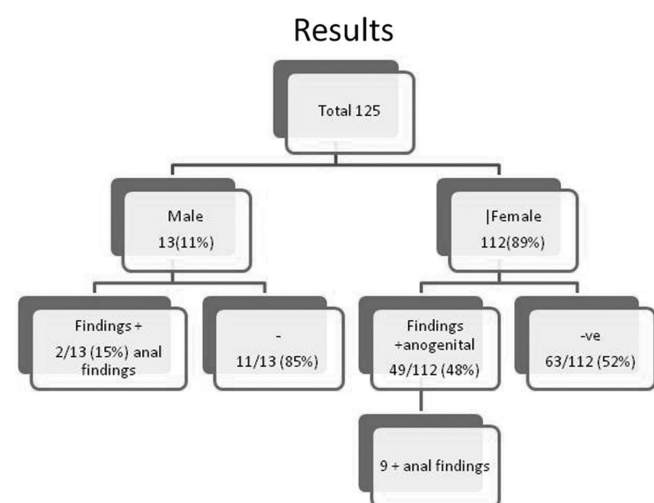
**Background** Few areas of paediatrics have expanded so rapidly in clinical importance as that of sexual abuse of children. What Kempe called a “hidden paediatric problem”<sup>1</sup> in 1977 is certainly less hidden at present. The NSPCC statistics April 2014 showed 1 in 20 children have been sexually 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

<sup>1,2,3</sup>BJA Stewart, <sup>1</sup>EL Baker, <sup>1</sup>U Venkatesh, <sup>1</sup>J Hourigan, <sup>2</sup>EJ Wyllie, <sup>3</sup>RK O'Rourke. <sup>1</sup>Child Health, York Teaching Hospital NHS Foundation Trust, York, UK; <sup>2</sup>Designated Professionals Team, North Yorkshire and York Clinical Commissioning Groups, Scarborough, UK; <sup>3</sup>School of Education, University of Leeds, Leeds, UK

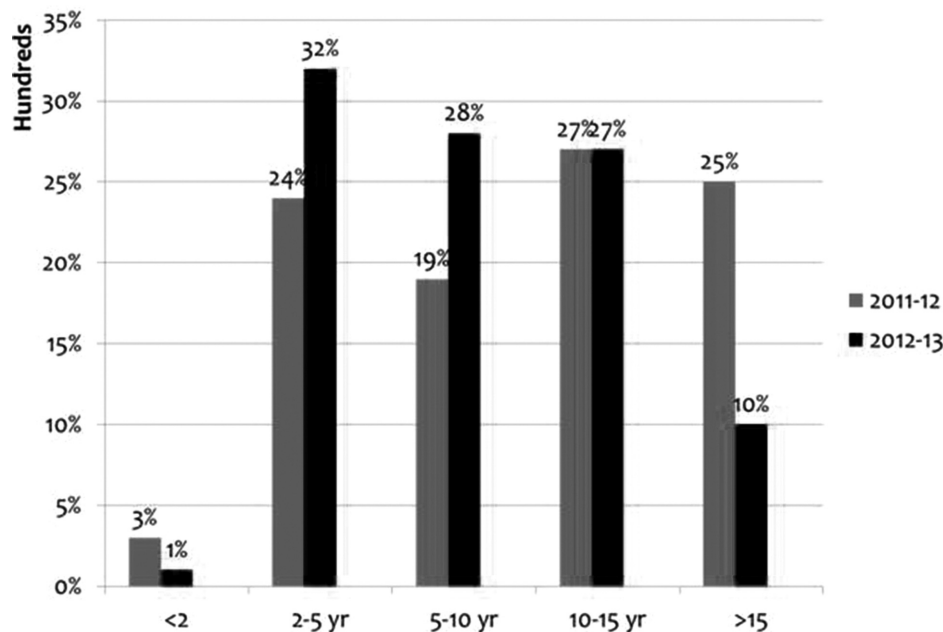
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**Aims** To establish regular peer review and reflective supervision for paediatricians at both sites of an NHS Trust for a six month period and evaluate participation and learning.

**Methods** An action research methodology was chosen. Morrison's 4 × 4 × 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



**Abstract G51(P) Figure 2** Age distribution

paediatricians' participation. There has been insufficient participation to evaluate learning or impact on outcomes for children. Future options to support participation will be discussed.

#### **G53(P) LISTENING TO CHILDREN AND YOUNG PEOPLE – THE VOICE OF THE CHILD IN CHILD PROTECTION MEDICALS**

<sup>1</sup>F Finlay, <sup>2</sup>JF Dunne, <sup>1</sup>E Hall. <sup>1</sup>Community Paediatrics, Sirona Care and Health, Bath, UK; <sup>2</sup>Safeguarding Quality and Patient Safety, NHS Wiltshire CCG, Devizes, UK

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**Background** The RCPCH Child Protection Companion 2013 states 'Record in quotes and verbatim. Record your questions, verbatim'.

Nurses have a long history of acting as advocates for children ensuring that children's and young people's voices are heard in relation to their health, well-being and care.

Children who had experience of the child protection system themselves 'voiced the importance of being heard separately from their parents and being listened to' (Munro, 2011).

**Aims** To examine whether the voice of the child was being heard and documented in our child protection medical reports.

**Method** All typed child protection medical reports by community paediatricians from January 2014 to November 2014 for children age 6 and above were examined (excluding child death).

Evidence in reports fell into 4 categories.

Documentation that the entire history was obtained from the child, negating the need for quotation marks.

Dialogue quoting specific questions asked and answers.

Selected quotes from the child.

Descriptive documentation without quotations e.g. child told me..., he explained...

**Results** 37 medical reports met the criteria. All 37 reports (100%) had one form of documented evidence the voice of the child had been heard.

10 of 37 (27%) reports the history was documented as obtained from the child, and within 3 of these there was also quoted dialogue.

2 of 37 reports (5.4%) contained documented dialogue.

17 of 37 (45.9%) documented selected quotes.

8 of 37 (21.6%) contained descriptive terms only.

**Conclusions** 100% of child protection reports examined had documented evidence that we listened to the voice of the child. There is much variability in how we as paediatricians are documenting this.

This variability reflects both the examiner, their experience and personal history taking style, as well as the child, their age, confidence, persons present and simply how much they are willing to share at that time.

There should be more joint working and training between Paediatricians and Children's Nurses to establish secure environments which help children find their voice, specifically in child protection medicals.

#### **G54(P) PAIN IN THE NECK! NON-ACCIDENTAL, NON-LETHAL ATTEMPTED STRANGULATION IN CHILDREN. A DESCRIPTIVE STUDY OF 6 CASES SEEN IN A YEAR**

V Rao. Child Health, Walsall Healthcare Trust, Walsall, UK

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**Background** The neck is a vulnerable part of the body due to its close proximity with major blood vessels, trachea and lack of bony protection. Neck injuries are more likely than not to be non -accidental. 2.5% of deaths worldwide are by strangulation.

Symptoms in survivors include bruising, hoarse voice, dysphagia, unconsciousness, surgical emphysema and psychological problems in the long term.

There is little literature about non-lethal, non-accidental strangulation injuries in children.

**Method** Case note review in a 12 month period of 6 children presenting with neck bruising and alleging to being strangled