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 SKELETAL 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: 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

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