identify and protect all girls and young women who are potential or actual victims of FGM.

G57(P) FOSTERING RESILIENCE: THE PROMOTION OF RESILIENCE IN YOUNG PEOPLE WHO ARE LOOKED AFTER

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Aims Children and young people who are Looked After have typically experienced significant adversity, with follow up demonstrating poorer social and developmental outcomes than their peers. However, risk factors are not the only predictor of outcomes. Attention is increasingly being focussed on promotion of resilience. There are multiple factors associated with improved resilience. Recurring themes for adolescents include (i) positive relationships with primary carers and with adults outside the family unit; (ii) positive experience of education; (iii) strong social networks, including participation in extra-curricular activities. Here we review the presence of these resilience factors amongst young people in our area.

Methods A questionnaire survey of Looked After young people aged 12–15 years was carried out in 2013. This covered various aspects of home and school life, as well as questions about physical and emotional well-being. Questionnaires were completed by young people either alone or with the support of their school nurse. Out of 84 young people eligible, opportunistic sampling resulted in 38 responses.

Results (i) **Adult relationships:** 95% reported that the people looking after them really cared about them, with 89% able to talk to a parent/carer about their worries. 79% felt able to talk to an adult who was not their parent/carer. 86% felt they were taken seriously most of the time.

(ii) **Education:** 58% agreed they liked being at school, with 66% thinking they were doing well at school. 98% described feeling quite/very safe at school and only 8% reported bullying within the last year.

(iii) **Social networks:** All reported having one or more good friends, although only 82% could talk to friends about their worries. 71% had taken part in structured extra-curricular activities recently, but 24% reported there were activities they would like to do but had no opportunity.

Conclusions This survey demonstrates high levels of certain positive resilience factors within our Looked After young people across the three highlighted areas. However, areas for improvement have been identified, including that all young people should have an adult in whom they can confide, and that experience of education is not always a positive one.

G58(P) MULTI-AGENCY REVIEW OF CHILD PROTECTION MEDICAL REPORTS

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The RCPCH Child Protection Companion provides guidance on medical report writing. We wanted to audit local medical reports against this guidance. Reports are shared with social care and police child abuse investigation team (CAIT), contributing to

decision making for children. We therefore wished to determine whether our local social care and CAIT teams felt the opinions in the reports were helpful to their decision making.

A retrospective audit of reports of 24 children seen in the first half of 2014 was undertaken, using section 16 of the RCPCH companion as standards. 3 reports from each of the 8 consultants were chosen at random. CAIT and social care reviewed the same 24 reports and completed a proforma regarding key aspects of the medical opinion.

Patients' details, consultation time/place, specific concerns, appearance of the child, past medical, family and developmental history were completed in all reports. 75% gave the child's own words where applicable, 89% gave information regarding school/nursery and 64% commented on parent/carer interaction. Most reports commented on the need for section 47 investigation but made no direct statement on whether it was safe for the child to return home. Social care and CAIT thought 19 and 16 reports respectively were helpful in decision making. Reported unhelpful factors were non-committal wording on the likelihood of NAI, ambiguity around sibling cases and lack of documentation regarding evidence for neglect concerns.

Clear documentation of patients' and consultation details reflects local strong administrative support. Key areas for child protection, notably the words of the child and child parent interaction were lacking and should be highlighted in training. Paediatricians may have made verbal recommendations during the medical but documentation of this is imperative. The satisfaction of CAIT/social care with reports depends upon their expectations as well as the doctor's clarity. In some cases the doctor could not have given a 'clear' opinion based on what was in front of them. It is valuable for local audits of child protection reports to involve local CAIT and social care to optimise the usefulness of reports in safeguarding of children.

British Society of Paediatric Dermatology and British Paediatric Neurology Association

G59 THE INTERNATIONAL COLLABORATIVE INFANTILE SPASMS STUDY (ICISS) COMPARING HORMONAL THERAPIES (PREDNISOLONE OR TETRACOSACTIDE DEPOT) AND VIGABATRIN VERSUS HORMONAL THERAPIES ALONE IN THE TREATMENT OF INFANTILE SPASMS: EARLY CLINICAL OUTCOME

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Infantile spasms (IS) are a serious epileptic encephalopathy that occur most commonly between 2 and 14 months. The spasms occur in association with hypsarrhythmia or similar on EEG. There is often coincident psychomotor arrest or regression. Between March 2007 and May 2014, infants with IS and a compatible EEG were enrolled in a multicenter treatment trial.

Participating countries were the UK, Germany, Switzerland, Australia and New Zealand. Infants were randomised to receive either hormonal therapy and vigabatrin or hormonal therapy alone. A second stage randomization allowed hormonal treatment to be allocated as either prednisolone or tetracosactide depot. Minimum doses were: vigabatrin 100 mg/kg/day, prednisolone 40 mg per day, or IM tetracosactide depot 0.5 mg on alternate days. Hormonal treatment was continued for 2 weeks and then weaned over 2 weeks. Vigabatrin was continued for 3 months and then weaned over a month. The early primary outcome measure was cessation of spasms on and between days 14 and 42. Analysis is by intention to treat. 377 children were enrolled and early clinical outcome data will be available on 376 (1 case withdrew). 186 were allocated hormonal therapy and vigabatrin and 191 were allocated hormonal therapy alone. We will report on the primary clinical outcome and serious adverse clinical events. Developmental outcome at 18 months of age will be reported in a subsequent paper. To date this is by far the largest treatment study of infantile spasms ever undertaken.

G60 STARTING ANTIEPILEPTIC MEDICATIONS BY NON SPECIALISTS: WHAT ARE THE HAZARDS?

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Background Initial prescription of antiepileptic drugs (AEDs) for newly diagnosed epileptic children should be done by a specialist. However many new patients start their treatment by paediatrician without expertise in epilepsy.

Aim To study the prescription of (AEDs) in children before they were referred to specialist (paediatric neurologist).

Methods This was a prospective study. Six hundred children referred for the first time to the epilepsy clinic in a tertiary university hospital were recruited. Detailed (AEDs) history was retrieved from the parents in their first visit regarding the number of seizure after which they start treatment, AEDs prescribed at the beginning of diagnosis and in the following 12 months, if the drug has changed and the reasons. Patients were classified as truly epileptic and non epileptic after being reviewed by 2 neurologists.

Results Truly epileptic patients represented 65% of the newly referred patients. Of those, 45% have started one or more of AEDs before referral. Thirty nine percent started after their first seizure. Monotherapy was initiated in 65% of epileptic patients. Sodium Valproate (65.1%) was the most frequently prescribed AED followed by Levetiracetam (41.0%) and topiramate (38.0%). The combination between Sodium valproate and Levetiracetam as a starting therapy was the most common. Twenty five percent of patients have changed the initial (AEDs) in the first 3 months of starting treatment. Worsening of seizures and non availability of the medication were the most common causes of changing (AEDs).

The non epileptic patients included diagnosis of: febrile seizures, breath holding attacks, pallid attacks and self stimulating. When offered to withdraw treatment after explanation of the condition by two neurologists, 28% refused to stop AEDs.

Conclusion Starting AEDs by non specialist paediatrician has the hazards of wrong diagnosis, inappropriate starting and changing of AEDs.

G61 A FIVE-YEAR RETROSPECTIVE REVIEW OF THE MANAGEMENT OF CHILDHOOD ENCEPHALITIS

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Background Early diagnosis and institution of appropriate treatment are key to improving outcomes from encephalitis. This study aimed to review the management of children with encephalitis in South East England.

Methods A retrospective review of clinical notes and electronic patient records (EPR) was conducted in between April 2013 and January 2014 across four hospitals (3 district general and 1 tertiary). Children aged 0–17 years who were admitted between 2008 and 2012 and had a discharge diagnosis of encephalitis were identified through the clinical coding department. Data on clinical features, investigation and treatment were collected.

Findings Medical records of thirty-four children were reviewed. A lumbar puncture was performed in 31 (91%) cases. A complete CSF order set (defined as CSF: white cell count, red blood cell count, gram stain, paired CSF and serum glucose and protein level) was requested in 21/30 (70%) cases. A complete PCR panel (CSF sent for the 3 main viral causes of encephalitis: enterovirus, herpes simplex and varicella zoster virus) was performed in 20/30 (67%) cases. The median time to performing a brain CT scan was 24 h (range 23–168) and 48 h (range 24–240) for brain MRI scan. The first dose of intravenous aciclovir was administered within 48 h for thirty-three (97%) cases. The prescribed aciclovir dose was incorrect in fifteen (44%) cases. The median duration of aciclovir treatment for children with enteroviral (EV) encephalitis was 5 days (IQR 2.5–5). The median length of hospital stay for the EV encephalitis group was 6 days (IQR 5.8–7.3). Six children with EV encephalitis received aciclovir treatment beyond 48 h due to non-availability of PCR test result. Children with EV encephalitis had a further median stay of 1.5 days (IQR 1.0–3.8) after availability of PCR result.

Conclusion The management of childhood encephalitis is heterogeneous. The recently published UK guidelines may help standardise practice. Widespread availability of PCR testing across hospitals and improved turnaround time could lead to early diagnosis and substantial cost saving from reduced hospital stay for infants with enteroviral encephalitis. Urgent steps are needed to reduce intravenous aciclovir prescribing errors.

G62(P) A CRITICAL APPRAISAL OF THE LITERATURE ON THE BENEFITS OF GASTROSTOMY FEEDING, COMPARED TO ORAL FEEDING, IN CHILDREN WITH CEREBRAL PALSY

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Aims To assess whether gastrostomy is a beneficial intervention for feeding children with cerebral palsy, compared with only oral feeding, for:

1. promoting growth and weight gain in children who have dysphagia and inadequate nutrition; and