G175(P) THE IMPACT OF CLOSE LIAISON WITH SOCIAL WORK ON HEALTH ASSESSMENTS IN LOOKED AFTER CHILDRENS Wilson, R Gibbs, J Young. *Paediatrics, Borders General Hospital, Melrose, UK*

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Aims Looked after children (LAC) are a vulnerable group who often have significant health needs. Scottish government guidance requires that they 'should have a health assessment within 4 weeks of notification to the Health Board'. The social work department are responsible for informing the health board as soon as the child becomes accommodated. The target identified was within two weeks. Our aim was to assess the impact of close liaison with social work and careful monitoring of our LAC database on the timings of the health needs assessments in LAC.

Methods Data was collected retrospectively from a database of LAC. Twenty children were selected at random from the date the health board was informed: between July 2015 to December 2015. Following this, the database was enhanced and liaison was done within the multi-disciplinary team to ensure there was regular monitoring of the children on it. Education with social work addressed early notification as a priority, with emphasis on timely consent from parents and the importance of the child's attendance at these appointments. The audit was repeated with data between November 2016 and August 2017 (tables 1 and 2).

Results**Abstract G175(P) Table 1** Timeframe from accommodation until LAC team notified

Audit	Mean (days)	Median (days)
2015	17	11
2016/2017	10	3

Abstract G175(P) Table 2 Timeframe from notification to LAC team until medical

Audit	Total number of children (n)	Within 4 weeks (n)	Within 6 weeks (n)	Mean (days)	Median (days)
2015	20	5 (25%)	8 (40%)	50	50
2016/2017	19	7 (37%)	13 (68%)	49	35

Conclusion Health assessments in accommodated children should be a priority for health professionals. Close liaison with social work has shown a significant improvement in the average time for the health board to be informed of newly accommodated children. Effective use and monitoring of our LAC database within the multidisciplinary team has improved the number of children seen within four weeks. There appears to be ongoing issues around consent from parents and failure to attend initial appointments. We are now considering other means of assessing the child's health needs ahead of the medical.

G176(P) SPECTRUM OF CHILDHOOD AND ADOLESCENT NEURODEVELOPMENTAL CASELOAD IN A COMMUNITY CHILD HEALTH CLINIC: EXPERIENCE FROM A MID-EASTERN SCOTTISH REGIONMO Ogundele. *Community Paediatrics Unit, Glenwood Health Centre, Glenrothes, UK*

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Community Child Health (CCH) is the branch of Paediatrics that specialises in childhood developmental-behavioural problems, such as ADHD, ASD, developmental delays emotional and behavioural issues. These problems are being increasingly recognised worldwide but the healthcare services available for addressing them are largely deficient.

Objectives We aimed to analyse the range of neurodevelopmental, behavioural and emotional (NDBE) disorders among children and young people seen in two CCH clinics of a Mid-Eastern Scottish NHS Trust over a 12 month period.

Methods A retrospective review of all patients seen in the out-patient clinics between June 2016 and May 2017 was carried out. The study was completed as part of an audit and the Clinical Governance strategies of the NHS Fife.

Results A total of 543 patients (28.1 per 1000 children's population), aged between 2 months and 18 years 6 months (Mean 104 months), 72% males, presented with an average of 3 NDBE conditions (ranging from 1 to 8), also under the care of average of 2 additional professionals.

The largest caseload of patients (46%) were seen in Summer. The highest proportion of children (30%) were from the most deprived 20% (Quintile 1) areas. The largest age-group of the patients (47%) were school-age (5–9 years) children.

There was a statistically significant relationship between the number of diagnosis and the number of professionals involved in the management of each patient. Commonest diagnosed NDBE categories were difficulties with Behaviour (45%), Sleep (30%), Social Communications (27%), DCD (24.5%), Sensory processing (22%), LD (19%), ADHD (17%), SALD (17%). ASD accounted for (13%) and GDD was 12%.

The commonest multi-agency professionals involved were the OT (33%), SALT (26%), HV (18%), CAMHS (17%), Educational- (16%) and Clinical-Psychologists (15%).

Conclusion This study highlights the significant public health importance of childhood Neurodevelopmental disorders involving over 2% of the population and requiring high levels of integrated multi-professional involvement because there is a high level of symptoms sharing and co-morbidity across various disorders. The high risk of future mental health problems in adulthood demands a corresponding long-term follow-up and surveillance of children with NDBE problems.

G177(P) SUDDEN INFANT DEATH SYNDROME IN TWINS – IS THERE A RISK TO THE SURVIVING TWIN?R Lee-Kelland, F Finlay. *Community Child Health, Royal United Hospital, Bath, UK*

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Introduction At a child death overview panel meeting, sudden infant death syndrome (SIDS) was recorded as the cause of death in two cases where the babies were twins. A panel member asked what the likelihood of a second twin dying was and whether it would be advisable to perform any investigations on a surviving twin.

Method A systematic literature review and analysis was completed using Medline, EMBASE and Cochrane databases to assess the question.

Results 3 studies were identified which addressed the question. Beal (1989) reviewed a series of 23 Australian studies dating from 1956–1988, finding 637 twin pairs affected by SIDS, in which 18 pairs (2.8%) both twins died. Malloy (1999) and Getahun (2004) analysed US records of twin deaths from SIDS comparing risk of death in a surviving twin to overall risk of death to a twin from SIDS. In Malloy 767 twin pairs died of SIDS in which 7 (0.9%) both twins died, giving a relative risk of SIDS in the surviving twin of 2.0 (95% CI: 1.0 to 4.3). In Getahun, 3/501 pairs (0.6%) subsequently died (RR 4.6 (95% CI: 1.6 to 15.1). Combining these two studies gave a RR of SIDS in the surviving twin of 2.3 (95% CI: 1.3 to 4.4.)

Conclusion These studies indicate that, although rare, there is an increased risk of death in the surviving twin. However, neither study is current or was completed in the UK. It is difficult to know how to manage a co-twin if it appears well, and we could find no published guidance on the subject. Following presumed SIDS, it may well be prudent to admit the surviving twin for observation and baseline blood tests. We believe this topic warrants further discussion.

G178(P) BURDEN OF CARE IN CHILDREN WITH EPILEPSY AND LEARNING DIFFICULTIES: MANAGEMENT CHALLENGES

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Aims To identify the unmet needs of children with Learning Difficulties (LD) and Epilepsy seen in a local service.

Methods Retrospective case note review using standard audit proforma were used to collect information on the standard of care for children with epilepsy and learning disabilities according to NICE guidelines. Case notes of 72 children with Epilepsy in 3 severe learning disability schools were reviewed.

Results Children with Epilepsy had a Joint clinic review by the Consultant Paediatrician and Specialist Epilepsy Nurse. Thirty-one (43%) children had used more than 3 anti-epileptic drugs whilst 80% of the children had been reviewed by the Paediatric Neurologist. Challenging behaviour was reported in forty three children (59.7%). Thirty children (41.6%) had anxiety concerns and 37 (51.3%) children reported mood disturbances. Twenty four (35%) of the children had a diagnosis of ADHD/ASD. Seventeen children (23%) had been seen by CAMHS for challenging behaviour with 12 (70.6%) of the children treated with medication for their behaviour. Social care involvement was seen in 52 (72%) children. Sleep difficulties requiring medication treatment were seen in 20% of the children.

Conclusion The audit showed the service is providing good medical care for children with epilepsy and LD however the study showed a gap in provision of social care support and management of challenging behaviour which is common in this population. The study highlighted that services are poorly commissioned for this group of children, with health care professionals, nurses and doctors responding to concerns which should be better managed by other services. The current medical model for management of epilepsy does not meet the needs for this population and emphasis should be on developing joined up working between health, social care and mental health services as this will improve the quality of life for the children and their families.

G179(P) WHY DO CHILDREN TAKE THEIR OWN LIFE? WHAT DOES THE DATA TELL US?

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Aims It is previously known that majority of the children who committed suicide had risk factors such as mental health problems, substance misuse and were in unfavourable social circumstances. However, these factors were unnoticed in all the children who committed suicide in our area when their case was individually reviewed at the Child Death Overview Panel (CDOP). Hence all suicides reviewed over a period of time was analysed.

Methods A retrospective analysis of the case details reviewed at CDOP from April 2011 to March 2017. The category of the death was 'Suicide or deliberate self-inflicted harm (category 2)'. The details of these cases as noted in the data set for this time period was analysed.

Results Eleven cases of 'Category 2' death were reviewed in this time period. Male: Female ratio was 7:4. Except two children (aged 12 and 14), all others were between 15–17 years old.

In six children, various risk factors such as mental health problems, substance misuse, self-harm behaviour and unfavourable social circumstances were noted either in the past or present, but in four children these factors were managed with appropriate intervention and were thought not to contribute to the death. In only two children it was felt by the panel that these factors could have been modified and contributed to the death.

In five children, no risk factors or modifiable factors were identified and there were no concerns expressed. One of these five children committed suicide during an exam period.

Conclusion Many risk factors, as above, are associated with suicide and need to be addressed with timely and appropriate intervention. However, it is also noticed that many children had no risk factors and their death seemed to be a sudden event. Factors such as peer pressure, easy access to social media, easy access and means to commit suicide, children's ability to manage stress such as exams are needed to be taken into consideration when we try to understand why children take their own lives.