Child protection special interest group and child protection standing committee

Plenary

P06 BASELINE CHARACTERISTICS AND PHYSICAL, SEXUAL AND EMOTIONAL HEALTH NEEDS OF A COHORT OF UNACCOMPANIED ASYLUM-SEEKING CHILDREN PRESENTING TO A LONDON BOROUGH

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10.1136/archdischild-2020-rcpch.411

Aims The meaningful health needs of unaccompanied asylum-seeking children (UASC) are poorly understood, preventing a fully informed population-based approach to planning health services. This lack of data around UASC has been identified as an unmet research need, as well as a rights of the child issue.

Here we describe the physical, sexual and emotional health needs of a population of UASC presenting to a London borough.

Methods Unlinked data were collected for UASC presenting to a London borough between January 2016 and March 2019, including data from initial health assessment (IHA) and infectious diseases (ID) screening.

Results During the study period 101 UASC were seen for IHA (84% male, age range 14–17, median age 16). Countries of origin included Eritrea (27%), Sudan (14%) and Ethiopia (12%). Two thirds of UASC disclosed historical physical assault/abuse including 16% who described experience of torture. On examination more than half, 54%, of UASC had scars consistent with their disclosures, and 9% had evidence of harmful traditional practices such as FGM, uvulectomy and scarification. Historical sexual assault or abuse was disclosed by 13% UASC, including 6 of the 16 (38%) female UASC. A further six UASC (6%) reported witnessing sexual assault. For 6/16 (38%) female UASC, there was evidence of trafficking and suspicion of undisclosed sexual assault/abuse.

The majority, 77% of UASC demonstrated symptoms of poor mental health including sleep problems and signs of trauma. Deliberate self-harm and parasuicide were reported at some point in 8% UASC.

Data are available for ID screening of 69 UASC from the same borough during the study period, of whom 28/69 (41%) had one positive ID result requiring treatment and 9/69 (13%) had two or more results requiring treatment. Diagnoses included latent TB (25%), schistosomiasis (13%) and other helminth infections (9%), and hepatitis B (6%).

Conclusion This cohort demonstrate high rates of trauma, physical and sexual abuse and unmet physical and mental health needs. This population require intensive, integrated support and health services to optimise engagement and physical health, mental health and social outcomes.

G481 SHOULD ALL CHILDREN WITH ANOGENITAL WARTS UNDERGO A SAFEGUARDING MEDICAL ASSESSMENT?

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10.1136/archdischild-2020-rcpch.412

Background Anogenital warts (AGW) in children are thought to be transmitted by vertical transmission, autoinoculation, hetero-inoculation, and sexual transmission.

In 2015 the Royal College of Paediatrics and Child Health (RCPCH) published guidance on the management of children with AGW. Based on evidence suggesting that a significant proportion of children (31%–51%) with AGW have been sexually abused, the RCPCH recommended that 'sexual abuse must be considered in any child presenting with AGW'.

In response to this, all children with AGW in our region currently undergo a safeguarding medical including detailed history-taking, genital examination with the use of a colposcope; and screening for sexually transmitted infections (STI's) and bloodborne viruses (BBV's). Assessment requires considerable time, cost and can result in anxiety for the child and family.

Aims To establish whether a safeguarding medical including screening for STI's and BBV's is of benefit in establishing whether children with AGW have been subject to sexual abuse.

Methods Case notes and investigation results of all children referred to our safeguarding unit with AGW (n 27), from 1st January 2017 to the end of September 2019 (33 months) were reviewed.

Results The majority of referrals (62%) were from General Practice, with only 1 referral coming from social care.

21 children had anogenital warts on examination. 6 (29%) were boys and 15 (61%) girls, ranging in age from 11 months to 13 years. 14 (67%) had never had contact with social care, 5 (24%) prior contact and 2 (9%) recent social care involvement. None had concerns about sexual abuse.

Warts were found in the peri-anal, scrotal and vulvar regions. No other signs suggestive of sexual abuse were noted. Of the 21 children, 19 (90%) underwent STI screening and 16 (76%) BBV testing. All results were negative.

14 children (67%) had contact with digital warts; 6 likely autoinoculation, 8 hetero-inoculation. In 3 children (14%) vertical transmission was felt most likely. In 4 cases (19%) transmission remained unclear.

Conclusions Neither safeguarding examination or investigations added evidence for sexual abuse. Safeguarding screening in General Practice may be sufficient to safeguard children with AGW who have no contact with social care or other risk factors for sexual abuse.

G482 RING THE ALARM; CHANGING OUR APPROACH TO HIGH-RISK SAFEGUARDING IN THE CHILDREN'S EMERGENCY DEPARTMENT

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10.1136/archdischild-2020-rcpch.413

Background Infants presenting with injuries are a high-risk group for potential safeguarding issues. The importance of appropriate assessment, recognition and response to concerns is highlighted in national guidance from both the emergency and child protection communities.

Aim We aimed to evaluate and improve compliance with:

- 'Facing The Future: Standards of Care in Emergency Settings' Standard 38: 'Infants, children and young people (ICYP) at high-risk of potential safeguarding presentations [eg. non-mobile infants with injuries] are reviewed by a senior (ST4+) paediatrician or PEM doctor'
- RCPCH Child Protection Companion, Section 5.4: Findings are consistent with history and development

Method We retrospectively audited notes of all infants <1 yr who presented to our Children's Emergency Department (CED) (~28000 attendances/year) in September 2018 for compliance with above standards.

Cases were included if triage presentation suggested injury (eg. 'head injury', 'bruise', 'bite'); if presentation was unclear notes were reviewed to determine inclusion.

Results

- 359 attendances of under-1s (16% of all attendances)
- 28 presented with an injury (8% of all under-1 attendances)

Mean age was 5.6m (10d-10m)

- 57% male
- Babies <5 months (considered fully immobile) accounted for a third
- 76% presented with head injury

Standards

- Standard 38-85% compliance
- Consideration of history- 39%
- Consideration of development- 19%
- Documentation of:
- Time of injury-76%
- Social history- 23%
- Clinical plan- 100%

Conclusion Though compliance with Standard 38 was good, other inadequacies in our current approach to infants with injuries were highlighted. Injury in infants, particularly head injury, is a common presentation to the CED. Our head injury proforma was felt to be unsuitable for use in infants; no 'infant injury proforma' exists.

To address this, we delivered departmental training and adapted our induction information. Furthermore, we developed and introduced a new 'Injuries in Under-1s' proforma. This includes additional space for documentation of reported injury mechanism and specifically addresses:

- Assessment of development/mobility
- Safeguarding screening questions
- Need for ST4+ review

Feedback from frontline staff suggests this aids both clinical and safeguarding decision-making. In order to complete the Plan-Do-Study-Act cycle we are currently in the process of re-audit.

G483

SAFEGUARDING CHILDREN: ADDRESSING ORAL HEALTH NEEDS IN CHILD PROTECTION MEDICAL ASSESSMENTS

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10.1136/archdischild-2020-rcpch.414

Background Children with safeguarding concerns experience a greater incidence of untreated dental caries and trauma. The mouth is sometimes the focus of abuse or neglect and dental professionals are best placed to recognise oral signs of maltreatment. The oral health needs of children undergoing child protection medical assessments are often overlooked due to little interdisciplinary collaboration between paediatricians and the dental team. We present a holistic approach to addressing the medical and dental needs of these children.

Aim To establish oral health assessments for children undergoing child protection medical assessments

Standard All children over the age of 6 months should receive oral health assessments by a paediatric dentist during their child protection medical assessments

Method A local referral pathway was developed for paediatric dentists to attend child protection medical assessments and a dental appendix was created for standardised recording of information. All children received basic prevention via a tooth-brushing pack. This protocol was piloted on 20 children and modified based on feedback. Data were collected using a validated tool and analysed retrospectively.

Results 100% of child protection medical assessments met the standard and 49% of the children assessed had unmet dental needs. All children with unmet dental needs were successfully referred to the dental team for further management.

Recommendations Training and inclusion of Paediatric Dentistry registrars in child protection medical assessments and increased stakeholder engagement are crucial to maintain this initiative in the long-term.

Conclusion Our project has improved patient care and safety of children undergoing child protection medical assessments by enhancing teamwork with paediatricians and increasing the contribution of dental professionals to child protection.

G484

THE CONTRIBUTION OF CHILD PROTECTION MEDICALS TO THE ASSESSMENT OF NEGLECT

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10.1136/archdischild-2020-rcpch.415

Aim To establish the main reasons children are referred for 'neglect medicals' and whether through these we are identifying additional unmet needs previously unrecognised and unaddressed in their social care/early help management plan.

Method Neglect is the most common form of child maltreatment but not a common indication for a child protection medical. The number of 'neglect medicals' conducted locally has increased, but we see nowhere near the number of children who are subject to neglect child protection plans. There is the impression that the request for these medicals comes once social care have been involved for some time, often when evidence is required for care proceedings. It is possible that there is an opportunity for earlier identification (and management) of needs.

All 'neglect medical' reports for children examined at a tertiary children's hospital within a six month time period (1/05/2018-31/10/2019) were reviewed. Follow up medicals and those where neglect was not the primary reason for referral were excluded.