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

¹S Datta, ¹N Lush, ²A Villis, ²C Grayson. ¹Department of Child Dental Health, Newcastle Dental Hospital, Newcastle upon Tyne, UK; ²Children and Young People Clinic, The Great North Children's Hospital, Newcastle upon Tyne, UK

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

¹F Blyth, ²K Davis, ³A Ramsbottom. ¹Paediatrics, Barnsley Hospital NHS FT, Barnsley, UK; ²Paediatrics, Sheffield Children's Hospital NHS FT, Sheffield, UK; ³Child Assessment Unit, Sheffield Children's Hospital NHS FT, Sheffield, UK

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.