ACEs are prevalent in the caseload though figures are likely an under-representation because currently this information is assessed informally and is clinician-dependant.

The CSA assessment is an opportunity to talk to CYP and families about mental health, ACEs and trauma with appropriate signposting. It is also an opportunity to work on building resilience in collaboration with a dedicated psychologist, social care, police, school and health visitors.

Proposals

- Focused mental health risk questions incorporated into the CSA proforma guiding onward intervention
- Develop a patient-led tool assisted by CYP user groups for collecting a robust ACE enquiry
- A bespoke 'Resilience plan' for each child.
- ACE –special interest group for sharing information and collaborating with other teams and multi-agencies.

G496(P) ABSTRACT WITHDRAWN

G498(P) CHILD PROTECTION (CP) MEDICAL REPORTS: ARE THEY USEFUL FOR THE MULTIAGENCY TEAM?

S Alladi, B Lee. *Community Paediatrics, Whittington Health, London, UK*

10.1136/archdischild-2020-rcpch.423

Aim Failures in multiagency communication are often highlighted in Serious Case Reviews. This project evaluated the usefulness of CP medical reports produced by the community paediatric team, amongst multiagency partners, in a London Borough.

Method The evaluation was in two parts:

- Anonymised reports, meeting RCPCH criteria and representing medical assessments for neglect, physical and sexual abuse were selected and shared with social care, legal, police, GP, Health visiting and school nursing teams. The reports were accompanied by online or paper questionnaires.
- In all cases seen for CP medicals between January–March 2018 and which progressed to conference, it was noted if:
 - a medical report was commented upon in the conference minutes and
 - if so, whether any action was taken based on the recommendations

Results In total 31 professionals each reviewed 3 CP reports with a total of 87 questionnaires completed

100% of professionals felt the reports contained useful information for their team.

99% of professionals found the reports easy to understand.

83% felt the conclusions were clear from the report.

71% felt the further actions for their team were clear.

Qualitative analysis of written comments highlighted the following:

Professionals in Social Care and the Police suggested:

- The significance of observations such as height/weight measurements should be explained

Professionals within Health suggested:

- To include important negative information e.g. normal parent's mental health status.

- Clear information regarding timelines and which team is responsible for follow up.
- To include more details about siblings as some professionals may receive only one child's report

In 58% of cases progressing to conference the CP medical report was mentioned in the conference report and the conference notes reflected actions based on the CP report recommendations.

Conclusion CP medical reports meeting the RCPCH Criteria are useful and easy to read for the multiagency team in this London Borough. Where reports are discussed at case conference the recommendations are considered as part of the subsequent actions. Improvements in the clarity of reports were suggested, specifically in identifying ownership of actions and timelines for multiagency partners. The paediatric department is now improving the writing of recommendations to multi-agency partners as well as developing a template for communication with families.

G499(P) LISTENING TO THE VOICES FROM THE CHILD PROTECTION MEDICAL EXAMINATION; WHAT ARE SECTION 47 MEDICAL ASSESSMENTS TELLING US?

¹P de Keyser, ²R Berg. ¹Paediatrics, Royal Free London NHS FT, London, UK; ²Paediatrics, Barts Health NHS Trust, London, UK

10.1136/archdischild-2020-rcpch.424

Aims To improve outcomes for children referred for Child Protection Medical Examinations (CPMEs) from two urban boroughs.

Methods 139 CPMEs completed in the year to 30 September 2019 were reviewed, to identify the referral source, the abuse suspected and alleged perpetrator, previous involvement with children's services, and current medical needs. 82 of the CPMEs involved siblings. 25 further CPMEs were requested, then cancelled.

Results 79 of the CPMEs related to referrals from schools and nurseries, 21 from social workers holding existing cases, 19 from police, 9 from family members, and 7 from Health Professionals.

124 referrals related to suspected physical abuse, and 15 to neglect. The alleged perpetrator, where identified, included parents in 99 cases, a parent's partner in 11, and another family member in 7. Domestic abuse was identified in 38 cases.

70 children were previously known to Children's services, 42 with Child Protection Plans and 10 as Children in Need. 3 were subject to Interim Care Orders, with these being sought in 9 further cases.

Current medical needs were identified in 67 children, with 16 instances related to developmental delay, 33 to the child's mental health, 4 to dental caries and 2 to obesity. 22 cases identified parents' mental health needs.

Educational concerns, including episodes of exclusion, were frequently associated with a child's mental health, or medical issues.

Conclusions Results are similar to our previously presented statistics in the 21 months preceding this study. Schools are key in reporting abuse. Referrals where neglect is suspected are still under represented, and thresholds for referral, sibling CPMEs, and cancellation appear at times variable.

Given the extent of medical and mental health needs, often unmet, in children attending for CPMEs, Children's Services might consider seeking medical reviews at an earlier stage for children known to them.

If educational and mental health professionals, and where relevant, Looked After Children's teams, had closer links to these medical assessments, then the CPME could prove a powerful tool in addressing the multiple needs of these vulnerable children.

G500(P) PRE-CERVICAL MYOSITIS OSSIFICANS SECONDARY TO NON-ACCIDENTAL TRAUMA

C Parfitt, N Sargant. *General Paediatrics, Bristol Children's Hospital, Bristol, UK*

10.1136/archdischild-2020-rcpch.425

We present a case report of a 7 week old baby, presenting with pre-cervical myositis ossificans secondary to non-accidental trauma.

Myositis Ossificans is characterised by bone formation within muscle or soft tissue. Majority of cases are caused by trauma. These usually occur in the extremities in older men and rarely in the head and neck area.

The baby presented to the Ear, Nose and Throat (ENT) team with a sub-lingual mass and stridor. Chest X-ray revealed multiple rib fractures of varying ages. An MRI scan of the neck detected a C6 vertebral body fracture and a pre-cervical calcified mass. A biopsy confirmed the diagnosis of myositis ossificans.

Skeletal survey also detected fractures involving the clavicle, humerus, bilateral tibiae and 5th metatarsal. Review by a Specialist in paediatric endocrinology and metabolic bone disease found no clinical, radiological or biochemical evidence of metabolic bone disease.

On clinical review, the baby was noted to have a linear submental laceration, mucosal tear of the soft palate and bruising of the tongue. No explanation was provided to account for these findings. History of an apparent life threatening event where mouth to mouth resuscitation was required with a delay in presentation to healthcare raised further concern about possible non-accidental injury.

Lower cervical spine injuries in infants are incredibly rare and accidental injuries tend to cause fractures in the upper cervical vertebrae. We have found one case report describing a C5 fracture with pre-cervical myositis ossificans in an infant secondarily to non accidental injury. The case histories and images are strikingly similar.

This case report highlights an atypical presentation of myositis ossificans in both age and location. It is important to raise awareness of this rare finding so that it can be considered in other cases and lead to earlier identification. These cases may trigger a case series to raise awareness of pre-cervical myositis ossificans as a marker for non-accidental injury.

G501(P) CULTURALLY BASED PRACTICES IN CHILD PROTECTION: A FRAMEWORK

¹E Botcher, ²J Gifford. ¹General Paediatrics, University Hospitals of Coventry and Warwickshire NHS Trust, Coventry, UK; ²Community Paediatrics, Coventry and Warwickshire Partnership NHS Trust, Coventry, UK

10.1136/archdischild-2020-rcpch.426

We live in a multicultural society and as paediatricians it is important for us to consider our patients within the context of their own culture. Culture is defined as societal norms and behaviours that change with geography, time, or even within generations of a family. What may be acceptable to one society may be utterly unacceptable in another.

Child Protection centres on the law of the land in which a potential crime has been committed in. Safeguarding however is not only about whether something is legal or illegal, it focuses on whether there is significant harm or risk of harm.

Cultural practices which may be harmful can be grouped into four overlapping areas: Gender Based Practices, Medicinal Practices, Body Modification for Cultural Identity, and Punishment. An event may fall into two or more categories, and they also fall along a spectrum of acceptability. For example, the piercing of a baby girl's ears would be a gender-based practice that has elements of bodily modification for cultural identity, but rarely would this be a safeguarding issue. If the baby girl in question had been subject to Female Genital Mutilation however, this would be a clear safeguarding (and legal) issue.

Following a local case which provoked discussion with the safeguarding team, the following framework was developed to consider whether something is a safeguarding issue:

- Is it legal in the UK?
- Is it harmful? (Including the degree of risk of harm)
- Is it morally/culturally acceptable?

In cases where a child presents to paediatricians for a child protection medical and there is doubt about whether an event or procedure is a safeguarding issue, this framework adds clarity and helps to structure conversations within the multi-disciplinary team.

G502(P) THE CHILD PROTECTION RECOGNITION AND RESPONSE (CPRR) COURSE, THE NEPALESE EXPERIENCE, 2016–2019

¹D Upadhyay, ²R Chapagain, ³N Sabde, ⁴C Hobbs, ⁵J Acharya, ⁶S Sharma, ⁷J Lott, ⁸B Giri, ⁹D Jellinek, ⁹J Price, ¹⁰S Shrestha, ⁸J Mae, ⁹R Smith, ¹¹R Kayastha, ¹¹B Banjhad. ¹Comm Paediatrics, CPFT, Cumbria, Barrow in Furness, UK; ²Hospital Paediatrics, Kanti Children Hospital, Kathmandu, Nepal; ³Comm Pediatrics(Retired), CPF, Cumbria, UK; ⁴Comm Paediatrics(Retired), Previously St James Hospital, Leeds, UK; ⁵Developmental Pediatrics, Alder Hey CH Hospital, Liverpool, UK; ⁶General Paediatrics, Sheer Memorial Hospital, Banepa, Nepal; ⁷Safeguarding Nurse, CMFT, Manchester Children Hospital, Manchester, UK; ⁸Hospital Paediatrician, Kanti Children Hospital, Kathmandu, Nepal; ⁹Retired Consultant Comm Pediatrician, UK; ¹⁰Hospital Paediatrician, Nepal Medical Hospital, Kathmandu, Nepal; ¹¹Sister, Kanti Children Hospital, Kathmandu, Nepal

10.1136/archdischild-2020-rcpch.427

Background The RCPCH CPRR course was developed following the Lord Laming Inquiry (2003) after the death of Victoria Climbié in 2000. These Courses are run by ALSG (Advanced life supportgroup) in several centres and adopted abroad in some countries including Nepal.

Aims

- To raise awareness of child abuse and neglect in Nepal.
- To encourage effective response including referrals to the appropriate agency.
- To support the development of a multi-agency response in the Nepalese context.

Methods and Results In 2016, the first Nepalese course was conducted at Kanti Children Hospital, Kathmandu by the