had initially anticipated but this did not reach statistical significance.

Conclusions SHO anxiety during the transition to middle-grade relates to the responsibility of managing emergency situations, but following a 6-month period of 'on the job' experience they identified managerial aspects of the role as the biggest challenge, more in line with what consultants had already identified as an important area for development.

Trainees responded positively to this near peer teaching programme with plans in place for this to be an annual event. Future iterations of the course need to be revised to continue to incorporate feedback from all stakeholders.

British Paediatric Neurology Association

1351 UNUSUAL DIFFERENTIAL FOR GENERALISED WEAKNESS IN A 10 MONTH CHILD

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10.1136/archdischild-2021-rcpch.579

Background A tenmonth old girl was referred to the Emergency department by her primary care physician with complaints of progressive generalised weakness. Parents started noticing significant weakness in both lower limbs with painful cries when pulled to sit and during nappy changes. She was born by IVF pregnancy at 32 weeks gestation and had an uneventful neonatal course. There were no concerns with regards to development and at age of ten months, she was able to Crawl/weight bear/stand prior to these new onset symptoms.

When examined, she was lying supine on a flat bed with noticeably reduced lower limb movements. Detailed neurological evaluation confirmed bilateral lower limb lower motor neuron type flaccid paralysis and absent reflexes. In view of rapid deterioration, Guillain Barre syndrome and transverse myelitis were the top differential diagnosis as she had no obvious sources or signs of infection. The child underwent necessary bloods and imaging of brain and spine as an inpatient. MRI spine revealed a solid extradural mass at level of L1– L3 reported as suspected nerve sheath tumour, likely schwannoma. She was transferred to a tertiary oncology unit where a diagnosis of adrenal neuroblastoma with spinal extension/compression was made in conjunction after biopsy and repeat MRI reports.

Background Neuroblastoma is the most common solid extradural tumor in children with 40% of the cases diagnosed under the age of one year. The adrenal gland is the most common primary site, followed by abdominal, thoracic, cervical and pelvic sympathetic ganglia. Primary tumours, usually in the retro peritoneum are able to invade the spinal canal through the neural foramina, creating a so-called 'dumbbell' tumor. The subsequent epidural spinal cord compression, an oncologic emergency, can cause pain, motor or sensory deficits, or loss of bowel and/or bladder control. The subtle and gradual onset of such neurologic symptoms in young children can make diagnosis difficult.

Objectives Not Required (case report)

Methods Not Required (case report)

Results Not Required (case report)

Conclusions Learning/conclusion :

Although not a very rare presentation for retroperitoneal (adrenal) neuroblastoma, but this was definitely a surprising and unexpected finding for a child presenting with predominantly lower limb weakness. On reflection, it could have been disastrous for the child and the family if left unnoticed or misdiagnosed. Every child should have a complete examination irrespective of presentation or magnitude of illness or complaint. All necessary imaging should be performed prior to more invasive investigations.

Child Protection Special Interest Group

1352 MISSING CHILD PROTECTION MEDICALS: A SERVICE EVALUATION OF REFERRALS FOLLOWING STRATEGY MEETINGS FOR PHYSICAL ABUSE

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10.1136/archdischild-2021-rcpch.580

Background The impact of Covid-19 on child abuse is widely reported. In Birmingham there has been an increase in strategy meetings occurring for children with alleged physical abuse but it is of concern that this has not corresponded to an increase in child protection medical examinations (CPME) occurring in a community healthcare trust.

Objectives To undertake a multi-agency service evaluation to identify the proportion of strategy meetings for physical abuse that led to CPMEs being undertaken, and to understand the reasons for not undertaking CPMEs.

Methods A list of children who had strategy meetings following allegations of physical abuse was obtained for the period 1st to 14th October 2020. Details of CPMEs were obtained from health care records and outcomes of CP enquiries from social care records.

Results There were 23 strategy meetings for physical abuse. 2 children were under 4 years, 14 were 4–11 years and 7 were over 11 years. There were 8 females and 15 males.

18 children (78%) did not have a CPME following the initial strategy discussion.

Social care records showed in 11 cases (48%) after the child/family were spoken to by social care with or without the police, the decision was made that a CP medical was not indicated, mainly because the history was not substantiated or injuries were not seen. This included one 3-year old and four 4-year olds.

Two children (aged 8 and 12) retracted their allegations; no information regarding injuries is recorded.

In 1 case the mother admitted to smacking the 8 year old child, she stated that she was unaware of the law as the family were new to the UK; there is no documentation with regards to injuries. One 15 year old refused to consent for CPME.

Conclusions CPMEs only occurred for 5/23 (22%) of children following their initial allegation of physical abuse. It is of concern that young children may make a disclosure to a 'safe' adult such as a teacher but then when they are unable to repeat the allegation to an unfamiliar social worker or police officer that further medical assessment is not sought.

A CPME will not always be offered by paediatricians in cases where there is no visible injury in a verbal child. GMC

guidance states that before carrying out a CPME you must be satisfied that it is necessary and appropriate. You must be clear about what will be achieved and whether or not the outcome is likely to affect the proposed course of action.

We therefore call for clarity between all agencies with regard to the threshold required for a CPME to occur following referrals received for physical abuse allegations.

We recommend that in preschool and younger children with limited verbal skills social workers should refer for a CPME to be undertaken where there is an allegation of physical abuse regardless of whether an injury is seen. In verbal children a CPME should be done when there is a significant allegation even if no injury is seen to ensure there are no hidden injuries.

Association of Paediatric Emergency Medicine

1354 SAFEGUARDING SIXTEEN AND SEVENTEEN-YEAR-OLDS IN THE EMERGENCY DEPARTMENT: DO PAEDIATRIC LED SERVICES IMPROVE OUTCOMES?

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10.1136/archdischild-2021-rcpch.581

Background 'Working together to Safeguard Children' (2018) is a document outlining government guidance for all professionals working with children. It states that 'children who need help and protection deserve high quality and effective support as soon as a need is identified', reminding us that 'health practitioners are in a strong position to identify welfare needs or safeguarding concerns'.

Paediatric departments regularly manage safeguarding cases; strategies to identify concerns are built into everyday practice. However, as we assume capacity to consent from the age of sixteen, 16 and 17-year-old adolescents may be managed by either adult or paediatric services, therefore could be seen by healthcare professionals with less experience safeguarding children. Nevertheless, concerns must be dealt with promptly and according to national guidance.

Our Emergency Department (ED), an inner-city major trauma centre, previously looked after 16 and 17-year-olds in the adult department. However, due to additional pressures during the COVID-19 pandemic, the paediatric ED has taken over their care.

Objectives To determine if there were improvements in how effectively safeguarding concerns were identified and acted upon when young people (YP) were managed by paediatric ED, compared to adult ED.

To use results to create sustainable change and improve services: firstly by providing targeted education for our workforce; and secondly by designing new ED pathways for YP which enable safeguarding concerns to be effectively managed. **Methods** This was a retrospective study of all sixteen and seventeen-year-old patients discussed in ED safeguarding meetings in September and October 2019/2020. Patients were identified and their notes reviewed by the auditing team.

Results Our results showed that safeguarding concerns were more effectively managed in 2020 by paediatric services (table 1). The values in table 1 are expressed as percentages of the total for each year. Thirty-three patients were discussed in safeguarding meetings in 2019, and ninety-one in 2020.

Abstract 1354 Table 1

	2019	2020
% Children's Social Care (CSC) involvement documented at triage	41%	55%
% acute safeguarding concerns discussed in real time with CSC when necessary	17%	56%
% of appropriate CSC referral/notification completed by ED team	74%	88%
% referral to violent crime reduction services made if appropriate	67%	59%
% school/college documented	42%	48%
% HEADSSS assessment documented	10%	19%

Conclusions Our results show that three times as many children were discussed in 2020, when paediatric ED led YP's care, and we saw improvements in all areas audited.

We presented our results to ED staff to highlight areas for improvement, and we are collecting feedback from the wider MDT to identify why safeguarding concerns are dealt with differently and what barriers staff are facing.

We are further investigating the discrepancy in numbers of YP discussed in safeguarding meetings between 2019 and 2020 by auditing specific discharge diagnoses that require safeguarding involvement (e.g. assault). This will allow us to identify whether lower numbers in 2019 were due to YP not being referred to the safeguarding meeting, or fewer patients presenting to the department.

Our results are helping to shape new ED pathways that increase involvement of paediatric staff with greater safeguarding experience in the care of YP, to ensure they are appropriately supported and protected.

Paediatric Mental Health Association

1355 OPENING UP IN LOCKDOWN: MAPPING CHILD & ADOLESCENT MENTAL HEALTH CRISES IN PAEDIATRIC A&E DURING COVID-19

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10.1136/archdischild-2021-rcpch.582

Background During the Sars-CoV2 pandemic, emergency care settings have continued to act as key contact points between healthcare professionals and young people experiencing acute mental health crises. Despite growing concerns that the psychosocial health and wellbeing of young people across the United Kingdom have been adversely affected by increasing social isolation, uncertainty and emotional trauma during successive national lockdowns, we are only now beginning to appreciate the impact of this phenomenon.¹

Objectives 1. Determine whether lockdown correlated with any significant difference in the number or nature of Child & Adolescent Mental Health Services (CAMHS) referrals in the Paediatric Emergency Department (PED).

2. Identify any health inequalities affecting young people referred to CAMHS during lockdown.

Methods We audited every patient aged 0–17yrs who attended PED at King's College Hospital during all three national lockdowns in England (n=5072) in 2020–2021, gathering data on age, gender, time of presentation, ethnicity, borough, source of referral, pre-existing safeguarding alerts, diagnosis, discharge