

Summary These children had neck bruising consistent with being held around the neck (Table 1). There were no serious consequences. 2 children sustained injuries when restrained by teachers, one disabled child throttled by step-dad for not going to bed. 3 cases were associated with domestic violence.

Conclusions When there are suspicions of attempted strangulation Child protection procedures should be followed even if there are no visible injuries as the child would continue to be at risk of harm.

Teachers should review their practice of restraint when dealing with violent children.

Adolescent girls, can be subjected to severe domestic abuse from their partners with of serious consequences.

Abstract G54(P) Table 1 Results of 6 children presenting with neck bruising

Case	Age (yrs)	Sex	Alleged abuser	Injuries	Explanation
1	9	M	Teacher	3 cms vertical bruise under ear	Restraint, fighting with peer Violent behaviour in class. Restrained by teacher
2	11	M	Teacher	Bruise on back: no neck injuries Bruises and scratches on neck	Autistic child; heard being slapped by step dad
3	11	F	Mother	Large bruise on neck Bruises, nail marks petechiae on lids, chest, behind ears	Child intervened in domestic violence
4	11	F	Step-dad	Neck injuries	Domestic violence
5	10	M	Step-dad		
6	14	F	Boyfriend		

More research on the long-term effects of children experiencing strangulation is required.

G55(P) FEMALE GENITAL MUTILATION: A SURVEY OF AWARENESS, TRAINING AND CURRENT PRACTICE

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Background “Tackling FGM in the UK”, Intercollegiate document calls for paediatricians to routinely ask about FGM in their clinical history to identify girls and young women who are at risk and require safeguarding.

Aims To gather paediatricians’ views at a large district general hospital on awareness, training and current practice regarding female genital mutilation.

Methods A pilot survey using Monkey Survey was compiled and sent out to paediatric registrars (ST3–ST8) which was followed by a survey to all paediatricians in the department. Questions included multiple choice and open ended format.

Results Out of 105 invitations 32 responses (30%) were received from 9 consultants, 19 paediatric trainees, 4 unknown. Most of those answering reported “some” knowledge about FGM (88%) although only 6% said they had “adequate” knowledge. The source of information was through professional teaching in 66% and by the media in 34%. Only half of the sample (58%) thought FGM to be a cultural issue but most (97%) thought FGM to be a safeguarding issue. Of the 32 responses

53% had looked after a patient either who had been subjected to FGM themselves or with a mother/sister known to be affected. Open questions garnered comments on how doctors became aware of FGM in patient or female relatives; the confidence required to ask about FGM in history taking and management of suspected cases.

Conclusions The findings of this survey represent the views of a small number of paediatricians in a general hospital. The poor response rate could suggest lack of awareness of FGM or that surveys are not a way of gathering the views of busy paediatricians. Paediatricians taking part felt almost unanimously that FGM is a safeguarding issue although there was less certainty about cultural issues. The survey identified a significant training need to help paediatricians identify and manage possible cases of FGM.

G56(P) FEMALE GENITAL MUTILATION: KNOWLEDGE, TRAINING AND EXPERIENCE OF HEALTHCARE PROFESSIONALS AT A LONDON HOSPITAL

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The World Health Organisation defines female genital mutilation (FGM) as “procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.” Since 1985 it has been a criminal offence in the UK to perform FGM, or to assist a girl in performing FGM on herself.

This study was based at a district general hospital in London with a high prevalence of patients originating from countries where FGM is practiced. We aimed to assess healthcare professionals’ knowledge and confidence in managing FGM, as this underpins their ability to respond adequately to the medical needs of patients with FGM and safeguard girls and young women from the practice.

A confidential survey was distributed within the hospital from January–March 2014. 157 healthcare professionals responded. 35% were midwives (n = 51), 45% medical doctors (N = 71), 19% nursing (N = 30), 3% other (N = 5).

100% of respondents stated they knew what FGM was and 71.4% felt they would benefit from further training on the subject. Only 21% of respondents stated that they would feel comfortable discussing FGM with patients. Most healthcare professionals had not read any guidelines relating to FGM (65.3%). Midwives were more likely to have read guidelines compared with any other profession (p = 0.001).

Interestingly, 73% felt there were barriers that prevent healthcare professionals from speaking to patients about FGM. On a scale of 1–5 (1 = not important at all, to 5 = very important), lack of knowledge of FGM was rated as the most important barrier with a mean rating of 4.3 out of 5, followed by a language barrier (rating = 4.1) and fear of appearing culturally insensitive (rating = 3.9).

We have identified what are perceived by healthcare professionals to be the most significant barriers to discussing FGM with patients. We suggest that future training should particularly focus on overcoming these barriers. One potential approach would be specialised communication training provided by people who are already familiar with working with women who have suffered FGM. These barriers should be addressed if we are to

identify and protect all girls and young women who are potential or actual victims of FGM.

G57(P) FOSTERING RESILIENCE: THE PROMOTION OF RESILIENCE IN YOUNG PEOPLE WHO ARE LOOKED AFTER

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Aims Children and young people who are Looked After have typically experienced significant adversity, with follow up demonstrating poorer social and developmental outcomes than their peers. However, risk factors are not the only predictor of outcomes. Attention is increasingly being focussed on promotion of resilience. There are multiple factors associated with improved resilience. Recurring themes for adolescents include (i) positive relationships with primary carers and with adults outside the family unit; (ii) positive experience of education; (iii) strong social networks, including participation in extra-curricular activities. Here we review the presence of these resilience factors amongst young people in our area.

Methods A questionnaire survey of Looked After young people aged 12–15 years was carried out in 2013. This covered various aspects of home and school life, as well as questions about physical and emotional well-being. Questionnaires were completed by young people either alone or with the support of their school nurse. Out of 84 young people eligible, opportunistic sampling resulted in 38 responses.

Results (i) **Adult relationships:** 95% reported that the people looking after them really cared about them, with 89% able to talk to a parent/carer about their worries. 79% felt able to talk to an adult who was not their parent/carer. 86% felt they were taken seriously most of the time.

(ii) **Education:** 58% agreed they liked being at school, with 66% thinking they were doing well at school. 98% described feeling quite/very safe at school and only 8% reported bullying within the last year.

(iii) **Social networks:** All reported having one or more good friends, although only 82% could talk to friends about their worries. 71% had taken part in structured extra-curricular activities recently, but 24% reported there were activities they would like to do but had no opportunity.

Conclusions This survey demonstrates high levels of certain positive resilience factors within our Looked After young people across the three highlighted areas. However, areas for improvement have been identified, including that all young people should have an adult in whom they can confide, and that experience of education is not always a positive one.

G58(P) MULTI-AGENCY REVIEW OF CHILD PROTECTION MEDICAL REPORTS

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The RCPCH Child Protection Companion provides guidance on medical report writing. We wanted to audit local medical reports against this guidance. Reports are shared with social care and police child abuse investigation team (CAIT), contributing to

decision making for children. We therefore wished to determine whether our local social care and CAIT teams felt the opinions in the reports were helpful to their decision making.

A retrospective audit of reports of 24 children seen in the first half of 2014 was undertaken, using section 16 of the RCPCH companion as standards. 3 reports from each of the 8 consultants were chosen at random. CAIT and social care reviewed the same 24 reports and completed a proforma regarding key aspects of the medical opinion.

Patients' details, consultation time/place, specific concerns, appearance of the child, past medical, family and developmental history were completed in all reports. 75% gave the child's own words where applicable, 89% gave information regarding school/nursery and 64% commented on parent/carer interaction. Most reports commented on the need for section 47 investigation but made no direct statement on whether it was safe for the child to return home. Social care and CAIT thought 19 and 16 reports respectively were helpful in decision making. Reported unhelpful factors were non-committal wording on the likelihood of NAI, ambiguity around sibling cases and lack of documentation regarding evidence for neglect concerns.

Clear documentation of patients' and consultation details reflects local strong administrative support. Key areas for child protection, notably the words of the child and child parent interaction were lacking and should be highlighted in training. Paediatricians may have made verbal recommendations during the medical but documentation of this is imperative. The satisfaction of CAIT/social care with reports depends upon their expectations as well as the doctor's clarity. In some cases the doctor could not have given a 'clear' opinion based on what was in front of them. It is valuable for local audits of child protection reports to involve local CAIT and social care to optimise the usefulness of reports in safeguarding of children.

British Society of Paediatric Dermatology and British Paediatric Neurology Association

G59 THE INTERNATIONAL COLLABORATIVE INFANTILE SPASMS STUDY (ICISS) COMPARING HORMONAL THERAPIES (PREDNISOLONE OR TETRACOSACTIDE DEPOT) AND VIGABATRIN VERSUS HORMONAL THERAPIES ALONE IN THE TREATMENT OF INFANTILE SPASMS: EARLY CLINICAL OUTCOME

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Infantile spasms (IS) are a serious epileptic encephalopathy that occur most commonly between 2 and 14 months. The spasms occur in association with hypsarrhythmia or similar on EEG. There is often coincident psychomotor arrest or regression. Between March 2007 and May 2014, infants with IS and a compatible EEG were enrolled in a multicenter treatment trial.