NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Centre for Clinical Practice

Review of Clinical Guideline (CG89) – When to suspect child maltreatment

Background information

Guideline issue date: 2009

3 year review: 2012

National Collaborating Centre: National Collaborating Centre for Women's and Children's Health

Review recommendation

- The guideline should not be updated at this time.

Factors influencing the decision

Literature search

1. Through an assessment of abstracts from a systematic literature search, new evidence was identified that related to the following clinical areas within the guideline:
   - Physical features
     - Injuries
       - Bruises
       - Burns
       - Eye trauma
       - Fractures

        - Intracranial injuries
        - Oral injury
        - Spinal injuries
        - Visceral injuries
    - Anogenital symptoms, signs and infections
- Clinical presentations
    - Apparent life-threatening events
    - Attendance at medical services
- Emotional, behavioural and interpersonal/social functioning
- Parent–child interactions

2. No new evidence was identified in these areas which would invalidate the current guideline recommendations.

3. Initial intelligence gathering, qualitative feedback from other NICE departments, the views expressed by the Guideline Development Group, and the systematic literature search indicated that there were no additional clinical areas that required further focused literature searches.

4. No recent or ongoing clinical trials were identified that were within the scope of the guideline.

5. New evidence was identified which directly answered research recommendations in the original guideline relating to:

    - How abusive fractures can be differentiated from those resulting from conditions that lead to bone fragility and those resulting from accidents, particularly in relation to metaphyseal fractures.

    - The association between anogenital warts and sexual abuse in children of different ages.

However, this evidence does not invalidate the recommendations within CG89.

Guideline Development Group and National Collaborating Centre perspective

6. A questionnaire was distributed to GDG members and the National Collaborating Centre to consult them on the need for an update of the guideline. The respondents indicated that there was no new evidence within the scope of the guideline, however new evidence and ongoing research in relation to interventions were noted. No substantial modifications to any practices recommended by the current guideline were reported by respondents.

7. Ongoing research commissioned by the NIHR Health Services Research as part of the NHS R&D Service Delivery and Organisation Programme was identified. This research aims to develop a tool-kit to help foster a safeguarding culture within the hospital environment to detect children at risk of abuse and devise appropriate protective actions before discharge. It is due to complete in 2014.

8. GDG members highlighted the Munro Review of Child Protection as a potential source of new policies or priorities that would impact on the current guideline. It focuses on safeguarding and principles of child protection but does not provide specific detail or guidance relating to alerting features for identification of maltreatment by healthcare providers.

9. With regard to current inequalities in access to services or service provision not addressed in the current guideline 1 respondent suggested that NHS reorganisation may cause potential inequalities to access and increase risks for vulnerable children.

10. Overall, 1 respondent felt that the guideline did not require an update at this time. Conversely, 2 respondents felt that there was sufficient variation in current practice and evidence to warrant an update. However, no evidence was provided to support this view point and only

1 respondent detailed the areas that may require updating. These included: physical features (bruising in non-ambulant disabled children), sexual abuse (the RCPCH Physical Signs in sexual abuse is due to be published in 2013), adolescent neglect, and parent-or carer-child interactions (the importance of detecting lack of "mindedness" or attunement in carers towards infant).

Implementation and post publication feedback

11. In total 112 enquiries were received from post-publication feedback, most of which were routine. An issue relating to the wording of a recommendation on the provision of home education was raised. This was rectified and the recommendation wording altered for the republication in December 2009. There were also 3 enquiries relating to underage sex and legal issues within the guideline. These were clarified by and in line with guidance from the Crown Prosecution Service on 'consensual experimentation'.

12. The implementation programme led to a number of issues being raised at the time of the initial guidance publication. These included the need to effectively disseminate, raise awareness and embed the guidance into clinical practice. In addition, the provision of education and training for healthcare professionals was identified as an issue. NICE has produced education resources to support these areas.

13. Qualitative input from the field team recorded the following feedback in relation to this guidance: The guidance was welcomed as straightforward with easily understandable recommendations. However some recommendations were noted to be not specific enough, leaving too much to interpretation. It was suggested that the guidance should be of a higher profile as this would benefit other potential stakeholders who work with children at risk and potentially enhance joint working and save costs. However, it was noted that the guidance was clinically

based and may be less meaningful to other audiences with regards to some terminology.

Relationship to other NICE guidance

14. NICE guidance related to CG89 can be viewed in Appendix 1.

Summary of Stakeholder Feedback

Review proposal put to consultees:
The guideline should be not updated at this time.

15. In total 12 stakeholders commented on the review proposal recommendation during the two week consultation period. The table of stakeholder comments can be viewed in Appendix 2.

16. Seven stakeholders agreed with the review proposal, 3 stakeholders disagreed, 1 stakeholder was undecided and 1 stakeholder offered no opinion on the proposal.

17. Stakeholders commented that:

A recent case of vitamin D deficiency in a young child had been misdiagnosed as child maltreatment, with the alerting factors including fractures and intracranial injuries. CG89 recommends that child maltreatment should be suspected if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones. Whilst the current guideline does not specifically mention vitamin D deficiency, no peer reviewed evidence which meets the criteria for inclusion was identified. In terms of vitamin D insufficiency, the only evidence identified in this area indicated that it was not associated with multiple fractures or diagnosis of child abuse. However there is a large body of evidence that indicates that fractures in children can be indicative of maltreatment.

In summary, no evidence was identified that would invalidate the current recommendations.

Anti-discrimination and equalities considerations

18. No evidence was identified to indicate that the guideline scope does not comply with anti-discrimination and equalities legislation. The original scope is inclusive of all children under 18 years and provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. The guidance is of relevance to those who work in or use the NHS in England and Wales and in the independent health sector and should prompt all healthcare professionals to think about the possibility of maltreatment. The guideline does not address risk factors for child maltreatment, service organisation, child protection procedures, communication of suspicions to parents, carers or the child and education and information for parents, carers and the child.

Conclusion

19. Through the process no additional areas or alerting factors were identified which would indicate a significant change in clinical practice. No evidence or intelligence described above indicated that the current guideline recommendations were invalid.
20. The Maltreatment guideline should not be updated at this time.

Relationship to quality standards

21. This topic is not part of the library of NICE Quality Standard NHS healthcare topics.
22. This topic is not currently related to a published quality standard or a quality standard in development.

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Centre for Clinical Practice
21st August 2012

Appendix 1

The following NICE guidance is related to CG89:

Guidance	Review date
CG9 Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders 2004	2014
CG111 Nocturnal Enuresis in Children (Bedwetting): the Management of Bedwetting in Children 2010	2013
CG99 Constipation in Children: the Diagnosis and Management of Idiopathic Childhood Constipation in Primary and Secondary Care 2010	2013
CG16 Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care 2004	2014
CG77 Antisocial personality disorder 2009	2015
CG113 Longer-term care and treatment of self-harm 2011	2014
CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors 2010	2013
CG128 Autism in children and	2014

young people 2011	
Related NICE guidance in progress	
Autism: the management and support of children and young people on the autism	Publication date: 2013
Conduct disorders and antisocial behaviour in children and young people: recognition, intervention and management	Publication date: 2013

Appendix 2

National Institute for Health and Clinical Excellence

CG89 When to suspect child maltreatment

Guideline Review Consultation Comments Table
16 July - 30 July 2012

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
Association of Anaesthetists of Great Britain and Ireland	Yes	The AAGBI has seen the review proposal and has no further comment to make.			Thank you for your comment.
Association of paediatric emergency medicine	Yes	No comment	No comment	No comment	Thank you for your comment.
British Association for Adoption & Fostering	no	The findings on head injury from the April 2012 High Court case Islington versus Al-Alas and Wray (Case No: FD10C00445) should be included in updated guidelines.			Thank you for your comment. CG89 recommends that child maltreatment should be suspected

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
(BAAF)					if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones. Whilst the current guideline does not specifically mention vitamin D deficiency, no peer reviewed evidence which meets the criteria for inclusion was identified. The only evidence identified in this area indicated that vitamin D insufficiency was not associated with multiple fractures or diagnosis of child abuse. However, there is a large body of evidence that indicates that fractures in children can be indicative of maltreatment. It should also be noted that the guidelines purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
					maltreatment.
British Association for Adoption & Fostering (BAAF)				Our members are concerned about existing inequalities in access and current service provision and the potential for this to worsen given financial cutbacks and the major reorganisation of the NHS. Service provision needs to be addressed in the guidance.	Thank you for your comment. Service provision is outside the scope of the guideline.
British Association for Adoption & Fostering (BAAF)		This is complex work which requires considerable resources and a highly skilled workforce with competencies and training at the levels specified in the 2010 RCPCH guidance Safeguarding Children and Young People: Roles			Thank you for your comments. Healthcare professionals' competency, training and behaviour, including behavioural change and the type of healthcare

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
		and Competences for Healthcare Staff. This should be reflected in revised guidance particularly given the major reorganisation of the NHS and in particular an increased number of Clinical Commissioning Groups (CCG) that may not have a good understanding of the complexity of this work and the resources, competencies and training required.			professional who should consider maltreatment, service organisation and child protection procedures, are all outside of the scope of CG89.
Department of Health	Yes	I can see where NICE are coming from in concluding that the guideline should not be considered for an update at this time. However, in the courts there are challenges which may create difficulties in implementation of the guideline. One relates to the vitamin D status of the child and sometimes the child's mother. This may need to be considered in interpreting whether fractures should trigger a consider or suspect maltreatment response, particularly as vitamin D deficiency and insufficiency are considered to be common in the population. The second and possibly much more difficult for			Thank you for your comments. CG89 recommends that child maltreatment should be suspected if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones. Whilst the current guideline does not specifically mention vitamin D deficiency, no peer reviewed evidence which meets the criteria for inclusion was identified. The only evidence identified in this area indicated that vitamin D insufficiency was not associated with multiple fractures or diagnosis of child abuse. However, there is a

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
		now, is that some of the evidence of injuries being associated with maltreatment is based on outcomes of previous child protection or criminal proceedings and much of that may be based on expert opinion. Such expert opinion seems to be increasingly questioned in the courts.			large body of evidence that indicates that fractures in children can be indicative of maltreatment. Establishing or diagnosing maltreatment is not within the scope of the guideline. The guideline focuses on alerting features that should prompt clinicians to consider or suspect child maltreatment. In addition, when considering the evidence base, verifying child maltreatment within a particular study is related to the inclusion criteria of that particular study.
Institute of Health Visiting/Royal Society for Public Health	YES	This is sound guidance. We would support its promotion for use by frontline staff and remind health colleagues that safeguarding and child protection responsibilities are applicable to all; including those working primarily with parents.			Thank you for your comments.
Lancashire Care NHS Foundation Trust	Yes	It seems sensible to review later, Working Together 2012 is out for consultation until 4th September but I don't think there is anything major that would impact on the original NICE guidance at this point	none	none	Thank you for your comments.
Medicines and		The scope of this guideline ('When to suspect			Thank you for your comments.

Stakeholder	**Agree ?**	**Comments** **Please insert each new comment in a new row.**	**Comments on areas excluded from original scope**	**Comments on equality issues**	**Response**
Healthcare products Regulatory Agency		child maltreatment') falls way outside our remit, so we will not be commenting.			
Royal College of General Practitioners	NO	Within a perpetually changing workforce we are trying to make Level 1 training in safeguarding children compulsory. Annual updates of the NICE Guideline would promote this, offering a useful focus for training of those with experience and a benchmark for those attending training for the first time.	I believe it would be helpful if comment was made under the section on “bites” that the size of the bite is a useful indicator as to whether the bite could have been administered by a slightly elder peer! (eg – more than 3 cms suggests it was no the result of a child’s bite)		Thank you for your comments. Clinical guidelines are currently updated only when there is new evidence indicating a change in clinical practice, or when there is new evidence that would invalidate the current recommendations. The guideline states that healthcare professionals need to ascertain the provenance of a bite mark. The recommendations in this area were made by Delphi consensus and it was noted that it was difficult to distinguish bites made by child dentition and bites made by adult dentition without expert input. No evidence relating to size of bites was indicated.
Royal College of Nursing		This is just to let you know that the feedback I have received from nurses working in this area of health suggest that there is no additional comments to submit on draft proposal for the			Thank you for your comments.

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
		review to update the above guidelines. Thank you for the opportunity to review this document.			
Royal College of Paediatrics and Child Health	No	There is still one flaw in the document, which was commented upon in the previous round but which was not addressed then. In stressing the importance of consultation with senior colleagues the guidance failed to emphasise that individuals, irrespective of grade or discipline, have a duty to report suspected abuse to the relevant authorities. This duty remains even if they are overruled by seniors, if they continue to have concerns. This point was well made in the Climbie enquiry, and it is a pity if it is to all intents and purposes made a dead letter by NICE guidance.	No	No	Thank you for your comments. The guideline states that when child maltreatment is suspected the healthcare professional should, 'refer the child to children's social care, following Local Safeguarding Children Board procedures.' It also states that when considering child maltreatment do one or more of the following: Discuss concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague or named/designated professional for safeguarding Gather collateral information from other agencies and health disciplines Review child or young person at an appropriate date

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					At any stage of during the process of considering child maltreatment the level of concern may change and lead to either exclude or suspect child maltreatment.
Royal College of Paediatrics and Child Health	Yes	We think it's a helpful update of the literature since publication of NICE guidelines, and no significant findings have been identified to consider a fuller review.	No	No	Thank you for your comment.
Royal College of Paediatrics and Child Health	Yes	There is no new evidence from recently published work in this field that requires material revision of the guideline	No	No	Thank you for your comment.
The Five Percenters	Yes	What we want to make sure is that ALL possible tests are done for possible disorders (including genetic) before a possibility of abuse is finalised, and that social workers are informed that at present this is one of a number of possibilities.			Thank you for your comments. This guidance provides a summary of the clinical features associated with maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
					healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child maltreatment.
The Five Percenters		As a child and parent organisation we believe that in order for better detection rates of child abuse and non-child abuse there needs to be a Nationwide protocol called 24:14 to rider the guideline and be immediately accessible in busy A&E departments.			Thank you for your comments. NICE's clinical guidelines are freely available to all members of the NHS and the public via the internet.
The Five Percenters		24:14 will 24:14 ensures that babies/children are seen by a Paediatric specialist within the first 24 hours of admission.			Thank you for your comments.
The Five Percenters		Then reviewed up to 14 days later to get a clearer medical picture			Thank you for your comments.
The Five Percenters		24:14 acts as a summary of other innocent medical, genetic, accidental trauma the mimic the injuries commonly associated with child abuse			Thank you for your comments.
The Five Percenters		24:14 will help over 70,000 children in the UK that are affected by child abuse and misdiagnosis of child abuse each year **Source:*			Thank you for your comments.

Stakeholder	Agree ?	**Comments** **Please insert each new comment in a new row.**	**Comments on areas excluded from original scope**	**Comments on equality issues**	**Response**
		Department of Education & Skills 24:14 will reduce the £1 billion the UK spends each year dealing with the aftermath of child abuse rather than its prevention** ***Source: National Commission of Enquiry into the prevention of child abuse 1996*			
The Five Percenters		**24:14 prevents cases like:** 'Baby P' missed for abuse and The most recent case of Rohan and Chana Wray a couple wrongly accused of shaking their son Jayden to death when Vit D deficiency was the cause			Thank you for your comment.
AIMS	No	GENERAL			
		1. A problem with this area of medicine is that a multidisciplinary group is involved both in the diagnostic process (eg major contribution of "grey" information from social workers with no evidence-base) and follow up, and actions affecting health, wellbeing and relationships of children and families are thereafter outside doctors' control. A large scale USA randomised trial of similar social work and action with long term follow up (after excluding immediate high risk			Thank you for your comments. Interventions for child maltreatment and their follow up by social workers are outside the scope of this guideline (CG89).

Stakeholder	Agree ?	**Comments** **Please insert each new comment in a new row.**	**Comments on areas excluded from original scope**	**Comments on equality issues**	**Response**
		cases) has shown that such interventions are damaging and do not improve child safety compared with supportive work with families.(1) This bears out the extensive material in our case files. Moreover referral to social services was associated with maternal suicide in the last three Confidential Enquiries into Maternal Death, and the most recent suggests that such referrals should be carefully considered for this reason. (2) 2. The heading for this guidance is "When to SUSPECT child maltreatment." However, we and other consumer support groups are deluged with complaints from innocent parents that suspicions are treated as certainties by medical, nursing and midwifery staff from the outset, with damaging long-term consequences even if children are not removed, and from then on evidence is sought by social workers only to confirm the diagnosis. Although NICE rejected our concerns on the original consultation, we wish to point out that other guidelines do incorporate advice on how patients should be treated (eg antenatal,			This guidance provides a summary of the clinical features associated with maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child maltreatment. Postnatal, antenatal and mental health care are outside

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		postnatal and mental health care). Once they have experienced this problem many families avoid health, nursery and/or state school care, thereafter, as well as concealing future health concerns. A study in Ohio shows that fear of being reported to child protection services is a factor preventing mothers discussing their problems with paediatricians. We are very concerned. (3) "Suspicions" of maltreatment often originate from non-medical sources, and the doctor may be invited (or even expected) to confirm these, rather than to undertake a thorough investigation. By this time, it is not surprising if parents are cautious about sharing information, which can add to suspicion. In such cases, extra care is needed. A survey of paediatricians in the US shows a wide level of thresholds for what they regard as reasonable suspicion(4). A study of British paediatricians' experiences with complaints shows their concern about a constantly changing, and uncertain, evidence base, as well as the strong reactions of parents to accusations and			the scope of this guideline. This guidance provides a summary of the clinical features associated with maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child maltreatment.

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		misdiagnoses . It also showed that paediatricians saw some colleagues as obsessive, or zealots, in diagnosing child abuse. (5) We therefore suggest *that "suspicion", and the possibility of it being unfounded, should be emphasised in written records, as well as the need for open-minded, supportive care.* 1, Extended Final study of Minnesota's Family Assessment Response Final Report. Institute of Applied Research, St. Louis 2. Saving Mothers' Lives 2006-8. BJOG Vol 118 Suppl. 1 2011 3. Will mothers discuss stress and depressive symptoms with their child's paediatrician? Amy Heneghan et al, Pediatrics 2004 113 460-7 4.Reasonable Suspicion: a study of Pennsylvania paediatricians regarding child abuse. Benjamin Levi, Georgia Brown Pediatrics 116 2005 5-12 5. An investigation into the impact of complaints made against paediatricians involved in protection proceedings. Jackie Turton, Linda Haines. RCPCH 2007 3. The preamble points out that the			NICE only considers peer reviewed

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		evidence base consists largely of observational studies, and it is not always clear if the children in studies were abused or suspected of being abused. We wish to point out that there is a dearth of case reports in the medical literature on false-positive diagnoses, though a search of the popular media would reveal many. In addition, we and other groups have many cases where proof of misdiagnosis became available only after a lengthy interval , and is not linked with the original diagnosis (which may form part of a published series) In its recommendations on research gaps, we hope that NICE would draw attention to this.			literature in its systematic reviews. In addition, for this guideline, case reports that included only one subject were not included.
		BRUISING If a coagulation disorder is possible, there should be referral to a haematologist at an early stage. We know cases where families have given a history indicating this possibility, and further investigation is refused, or even blocked. Our particular concern, as a maternity group, is with cases of bruising in pre-mobile infants. Although the guideline is on “suspicion”, parents invariably report being treated as guilty from the beginning. Some also have older children, apparently thriving, who have never caused concern, who are doing well at school. Some			Thank you for your comments. This guidance provides a summary of the clinical features associated with maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals

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		can think of no reason for the bruising (in itself regarded as suspicious) while others think baby equipment or a boisterous (or jealous) slightly older sibling may be responsible. Babies, bonding and family life suffers, and there is loss of breast feeding, when separation occurs, as it frequently does. *We would urge that where reasonable causes are found, these should be published, so that at least the possibility of innocent causes is understood. Alas in many cases, no proof either way is found.*			with recommendations on how to diagnose, confirm or disprove child maltreatment.
		BURNS This says that maltreatment should be suspected if the "explanation is absent or unsuitable". We have a number of cases where the doctor, *without investigation* , regarded an explanation of suspected maltreatment as "unsuitable", and one was recently reported in the press (chemical burns from crystals in a disposable nappy which resulted in children being removed for 8 months). A quick internet search would have shown that such cases were well known in the USA.			Thank you for your comments. This guidance provides a summary of the clinical features associated with maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child maltreatment.

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		FRACTURES Schilling's study of cases of *suspected* child abuse is quoted as supporting the argument that Vitamin D status is not associated with fracture risk. However, the document does not mention the paper in the same issue of Pediatrics which disputes this conclusion. (Vitamin D Deficiency and Fractures in Childhood, Colin Paterson, Pediatrics 2011 127 973) We also wish to point out that risk factors listed for both abuse and neglect naturally are more common in families in poverty – which in itself is a major risk factor for nutritional defects,(and also a risk for injuries arising from poor housing, overcrowding, black mould on walls, etc. etc.) We are hearing of a number of cases where babies are found to have fractures, and reasonable parents can provide no history of a causal incident or sudden distress. Since current circular reasoning (unexplained fracture = abuse) does not require the doctor to seek further explanation, we are convinced many innocent families will continue to suffer.			Thank you for your comments. The paper that you refer to (Vitamin D Deficiency and Fractures in Childhood, Colin Paterson, Pediatrics 2011 127 973) is an opinion based commentary so did not meet NICE guidance inclusion criteria. Risk factors for child maltreatment are outside the scope of the guideline. The guideline states that when child maltreatment is suspected the healthcare professional should 'refer the child to children's social care, following Local Safeguarding Children Board procedures.' The guideline does not cover confirmation of child maltreatment.
		INFECTIONS – (sexually transmitted) We are concerned that suspicion is apparently			Thank you for your comments. CG89 makes numerous

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		restricted to cases under the age of 13. We have seen cases where sexual abuse has occurred in foster care over this age, where children were disbelieved – in one case until it escalated to rape by the foster carer's son. Medical reaction to signs of sexual activity is often to put the girl on the pill or contraceptive injections, seeing pregnancy as the main problem and ignoring the increased risk of future cancer of the cervix from early intercourse, as well as the profound emotional harm of possible abuse or coercion. We would also draw attention to the increasing number of cases reported to us by parents of sexual abuse of children by children.. This seems to be an increasing problem in schools, and parents who report it to teachers tell us of hostile and defensive reactions from the school. Parents are also reluctant to involve official services for fear of accusations against them. APPARENT LIFE THREATENING EVENTS *We are concerned that country of origin is not quoted for research where this may be relevant.* For example, Guenther's USA retrospective study of 627 cases of ALTE, cites calls to emergency services as a the first risk factor, being more common in the 9 cases attributed to			recommendations on sexually transmitted infections in children and these are not all limited to children under the age of 13. For example; Consider sexual abuse if a young person aged 16 or 17 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection and there is: • no clear evidence of blood contamination or that the STI was acquired from consensual sexual activity *and* • a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) *or* • concern that the young person is being exploited. The country of origin of research is

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		abusive trauma. But in a country where parents do not have NHS GP and paediatric services,lay behaviour in accessing medical care is likely to be different. K Parker's USA study (ref 49) is quoted to support maltreatment as a potential diagnosis for infants presenting with ALTEs . Since social workers and other laypeople involved may quote this, it is useful to explain to them the statistics on which it is based. Of 563 cases, only 11 ALTE arrivals were diagnosed as abusive in cause,(1.195%) and we do not know if those were confirmed. 1 death was attributed to abuse – he quotes a rate of 9%, But with 1 death in 563 presenting cases, this is a mortality rate of 0.177% in ALTE cases from maltreatment. However ALL our parents whose infants have ALTEs for which no cause is found, report being treated with suspicion. And ALTEs are also more likely in babies born prematurely, or with problems. *These parents are thereafter afraid of seeking medical advice – which cannot be in children's best interests.* PARENT CHILD INTERACTIONS We agree on the importance of these. However, we would			not routinely quoted in an update review. The process involves only an assessment of abstracts. Full statistics are not reported. CG89 is a guideline designed to alert healthcare professionals to

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
		point out that the initiating entries of suspicious observations frequently come from social workers (not always qualified), nursery school staff (ditto) and other lay people, and are later "confirmed" by other similarly untrained or inadequately trained personnel, with disastrous consequences. These observations are hotly disputed by parents who know their children well, and often have good reasons for particular behaviour at one point in time. The skill and training needed for interpretation of child behaviour and interactions are too little recognized by the system. There is a dearth of professionals who are adequately qualified and trained.. The Select Committee report on social work training was swingeingly critical (1) and quoted evidence (Para 71) on gaps in social work degree courses on child development and knowledge of paediatric medical conditions, as well as (Para 76) lack of content on child behaviour and developmental stages, and what it is reasonable to expect a child to do. For example, premature babies are more likely to have both developmental and behavioural problems, but we have seen many cases where social workers attribute these to parental shortcomings.			alerting features of child maltreatment. It does not specifically deal with safeguarding or the social workers role. When a healthcare professional suspects child maltreatment, it is recommended that they, 'refer the child to children's social care, following Local Safeguarding Children Board procedures.' The guideline does not provide healthcare professionals with recommendations on how to diagnose, confirm or disprove child maltreatment.

Stakeholder	Agree ?	**Comments** **Please insert each new comment in a new row.**	**Comments on areas excluded from original scope**	**Comments on equality issues**	**Response**
		There are many criticisms from parents of children with autistic spectrum problems , for example, which are missed or misunderstood, not only by social workers, but also by doctors, health visitors, teachers, etc. Parental behaviour is criticised, controlled and punished, but the child's needs are not met. (1) House of Commons Children Schools and Families Committee Seventh Report. Training of Children and Families Social Workers. 2009.			The recommendations within CG89 state that when considering maltreatment, medical explanations, including for example autism spectrum disorders, should be taken into consideration.
		SUMMARY: Because of the system in which it is inevitably embedded, and multi-agency cooperation with laypeople who did not understand diagnostic limitations, mere SUSPICION of maltreatment carries potentially draconian consequences, and can result in long-term damage to families even if children remain, or are returned to, their home, as we have outlined above. *We therefore suggest the guidance is incomplete if it does not include information to doctors on how to deal with unconfirmed or disproved suspicions, and ensure that these are circulated to all agencies involved, and parents are supported so that*			Dealing with unconfirmed or disproved suspicions is outside the scope of the guideline.

Stakeholder	Agree ?	Comments Please insert each new comment in a new row.	Comments on areas excluded from original scope	Comments on equality issues	Response
		their trust in medical care is restored.			