National Institute for Health and Clinical Excellence

WHEN TO SUSPECT CHILD MALTREATMENT
Guideline Consultation Comments Table
16 December 2008 – 10 February 2009

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Alder Hey Children's NHS Foundation Trust	1	NICE	1.3.2	10	Petechiae can be found in 3% of well infants (Downes et al. Prevalence and distribution of petechiae in well babies. Arch Dis Child. 2002;86:291-2). The guideline needs to be clearer what pattern(s) of petechiae might suggest abuse.	Thank you for this reference. The evidence base used to inform the GDG regarding this recommendation was Nayak et al 2006. That showed petechiae are 6 times more likely to be seen in physical abuse than non abuse in children. There was no difference in the distribution of petechiae in the two groups. We therefore feel that the recommendation is justified as it stands. We recognise that there is sometimes no explanation for bruising of any type in children and have not included "absent explanation" within this recommendation.
SH	Alder Hey Children's NHS Foundation Trust	2	NICE	1.3.13	13	Retinal haemorrhages may be caused by meningitis – this should be added as an example of a medical condition that can give retinal haemorrhages.	Thank you for the comment. There are over 30 potential causes of retinal haemorrhages and it is difficult to mention all of them as the guideline is not intended to be a text book.
SH	Alder Hey Children's NHS Foundation Trust	3	NICE	1.3.26 and 27	16	Hepatitis B can be acquired child to child and by spread within families, not just by mother to child transmission. Either this should be clarified, or Hep B removed from this list.	Thank you for this comment. Hepatitis B has been removed from the list and has its own set of recommendations that account for household transmission.
SH	Alder Hey Children's NHS Foundation Trust	4	Full	2.1	25	the document refers to 'near drowning' according to the APLS manual this term should not really be used anymore	Thank you for raising this. We have amended this heading to "Non-fatal submersion injury (near-drowning)" and made changes in the text where appropriate.
SH	Alder Hey	5	Full	6.7	77 to	the FII (fabricated and induced illness group)	Thank you for your comments.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Children's NHS Foundation Trust				79	has met this morning and looked specifically at the part of the document related to FII pages 77 to 79 We have the following comments to make **1) Overview of evidence (page 77/78)** a) There needs to be reference to parental /carer psychopathology within the summary of evidence b) There needs to be reference to carers other than family members ie professional carers c) Make clearer reference to the possibility of induced mental health symptoms/signs **2) Evidence statement (page 78)** a) An additional statement should be added to the comment …"most common presentations are apnoea , diarrhoea etc " to highlight that any symptom/sign" to highlight and remind that any symptom /sign of physical /mental health may be presented **3) Recommendations (page 79 Para 1)** a) We would like to suggest the following as the introductory sentence under the heading recommendations "Health care professionals should consider FII as a relationship disorder and carers physical / mental health should be considered .If a child's	1a) We did not look at evidence on parental psychopathology as this is a risk factor for maltreatment and therefore outside the scope. b) We have used the term parent/carer to account for this. c) Induced mental health symptoms/signs have been addressed where relevant. 2a) In the GDG considerations, we have added "but any symptom or sign can represent FII." 3a and b) Mental health issues in the parent/carer are not independent features in the child and therefore outside the scope of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						history etc …" b) at the end of the list of recommendations " in addition to the above there may be evidence of mental health issues in the carer **4)Research recommendations (page 79)** a) Research into parental/carer psychopathology in relation to FII	4a) As parental psychopathology is outside the scope, it is not appropriate to make such a research recommendation.
SH	Alder Hey Children's NHS Foundation Trust	6	Full	General		A) The guidance is exclusively concerned with the identification of maltreatment without being clear what the degree of detail and specific formulation should be so that this identification then serves a purpose. Maybe it needs stating explicitly that identification should serve: 1) to enable action to protect the child; 2) criminal prosecution if indicated; 3) identification of need; 4) intervention & treatment. Each of these purposes will require its own specific standards of identification of maltreatment or suspected maltreatment. It would be helpful if this could be clearer. B) The text is entirely focussed on the child and therefore the relationship between the professional and the parent as an indicator of maltreatment does not come into it. That might be a bit too restrictive and it might be helpful to identify the helplessness and sense of having	Thank you for your comments. A) The operational definitions of consider and suspect are set out to enable action to protect the child but the remit of the guidance does not extend to prosecution, or assessments for intervention etc. B) Communication with parents and carers is outside the scope of the guidance. The GDG has addressed this in its highlighting of deterrents to recognising maltreatment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						to walk on eggshells, or a possible puzzlement because presentation and emotion are not congruous, as possible concomitants of maltreatment. C) The fact that parental pathology etc is not dealt with by the guidance does not absolve it from stating that the assessment of the parent in some detail is an essential task once maltreatment has been identified. This should enable a full understanding of the relationship patterns that result in child maltreatment for clinical purposes, including the full assessment of parental personality disorder if present either as primary or secondary diagnosis (in e.g. schizophrenia or depression) as the background to disturbed child-parent relationships. It would be helpful for children and their carers including clinicians to have this established. Otherwise maltreatment will be identified but not understood. D) There is a point made about the fact that a child taking on a 'care taking role with parents or siblings' may indicate maltreatment. While this is undoubtedly true, more often than not such a role is a child's coping mechanism that will allow them to deal with anxiety and can be a source of strengths (see Gopfert et al, 2004; also Breznitz, 1985, Chores as buffers against risky interaction). E) For 'treatment and intervention' it is important to acknowledge a long-term	C) Assessment of the parent is outside the scope of the guidance. D) It is the GDG's view that care-taking as a coping mechanism does not necessarily remove the possibility that it may be inappropriate for the child if it interferes with their development, even when part of a coping mechanism. E) Treatment and intervention is beyond the scope of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						perspective that needs to be included in everyone's thinking: There may not be any point in offering anything other than dealing with the concrete implications of maltreatment at the time of identification because the child needs to feel safe enough for anything else to be possible. When the child feels safer (s)he child may wish to explore some of the trauma in a therapeutic capacity. This often presents in the form of distress signals such as suicidal gestures, suicide attempts, or self harm. It then may be very important to have available documented evidence in accessible places (not the court or protection agency records only) providing as much information as is possible about the patterns of maltreatment so that their effect on the child's personality can be understood and dealt with. This often only becomes apparent in adulthood when people are able to take responsibility for themselves. Especially when the harmful events happened early in a child's life it might be crucial for therapeutic work to have some information about these patterns as otherwise therapy is more limited. For instance it can be very important to know whether an abuse pattern was seductive or demeaning. {*This is a little bit akin to very early PTSD where for instance it is not clear whether it is the noise of a car crash, or the mother's facial expression, or a particular feel of fabric that might have become the feared stimulus that sends the baby into recurrent dramatic and unmanageable states of mind. Then detailed information about what*	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						happened might be essential for treatment to be able to progress. Of course this is not always so and it is not always possible to capture such information either.) It would be helpful if this could be acknowledged in the guideline somewhere so that professionals are aware that their assessment and some of its details might have an impact on what is possible to do at a later stage. F) There is an issue about where information should be held. The general point here is that information about maltreatment must be fully and easily (!) accessible to clinical services, not just to protection agencies.	F) The recommendations on 'consider' and 'suspect' have been amended such that information leading to a consideration or suspicion of maltreatment are recorded on the child or young person's clinical record.
SH	Alder Hey Children's NHS Foundation Trust	7	full	general		The text is entirely focussed on the child and therefore the relationship between the professional and the carer as an indicator of maltreatment is missed. It might be helpful to identify the evidence around the professionals experiences of working with carers who maltreat their children	Thank you for this comment. Assessment of the parent is outside the scope of the guidance.
SH	Alder Hey Children's NHS Foundation Trust	8	full	general		The fact that parental psychopathology is not dealt with by the guidance does not absolve it from stating that the assessment of the parent in some detail is an essential task in the identification of child maltreatment	Thank you for highlighting this. Unfortunately, assessment of the parent is outside the scope of the guidance.
SH	Alder Hey Children's NHS Foundation Trust	9	NICE	1.6	1.6.7	Should all forms of medically unexplained physical symptoms be considered as possible indicators of child maltreatment rather than just abdominal pain	Thank you for this helpful suggestion. This is covered under fabricated and induced illness.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Alder Hey Children's NHS Foundation Trust	10	NICE	1.6	1.6.9	With regards to selective mutism, is there evidence that this social anxiety disorder is any more associated with child maltreatment than all social phobias	Thank you very much for this comment. The GDG acknowledges this was an area where we have been able to consider the issue afresh as result of your comment and the recommendation has been removed.
SH	Alder Hey Children's NHS Foundation Trust	11	Full		Lines 21/22	Importance of recognising that many adverse childhood experiences occur simultaneously – including domestic violence, parental alcohol and drug misuse; parental criminality and mental health programmes. The full impact of these adverse experiences on health is well documented. (See www.acesstudy.com)	Thank you for your comment. These adverse childhood experiences are risk factors for maltreatment and, as such, are outside the scope of this guidance.
SH	Alder Hey Children's NHS Foundation Trust	12	Full	General		Neglect due to mother's substance abuse in pregnancy – need to specifically include effects of alcohol	Thank you for your comment. Maltreatment of unborn children is a specific exclusion from the scope of this guidance. We are therefore unable to address this issue.
SH	Alder Hey Children's NHS Foundation Trust	13	Full	General		Children/ young people and families should also be given information about confidential ways of reporting suspicions/ concerns such as telephone lines like Childline by Health Care professionals	Thank you for your comment. Members of the public will be referred to appropriate organisations in the 'Understanding NICE guidance' for this guideline.
SH	Alder Hey Children's NHS Foundation Trust	14	Full	General		LAC can suffer child maltreatment within foster families and residential provision - clarity regarding guidelines to be followed is needed	Thank you for this comment. The indicators of maltreatment addressed in this guidance are primarily in the child. However, where appropriate, we have changed 'parent' to 'parent or carer' to take account of the issue you have raised. We hope this is helpful.
SH	Alder Hey Children's NHS Foundation Trust	15	Full	1.2.4		Cultural practices that are considered maltreatment – probably need to be specific – FGM being an obvious one	Thank you for this suggestion. The GDG's view is that mentioning specific (and obvious) harmful practices has the potential to detract from the general message.
SH	Alder Hey	16	Full	1.2.6		Children with no language or babies … as well	Thank you for your comment. This is covered

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Children's NHS Foundation Trust					as disabilities …	in the text about communication in the NICE version.
SH	Alder Hey Children's NHS Foundation Trust	17	Full	1.6.2		May like to consider PTSD presentations in childhood which can appear like ADHD, attachment difficulties and conduct disorders.	Thank you for this comment. The GDG, while not considering the diagnosis of PTSD as an indicator of maltreatment, has considered the elements that constitute it. These can be found in the recommendations about behaviour and emotional states.
SH	Alder Hey Children's NHS Foundation Trust	18	Full	1.7.1		May also like to consider parental mental ill health – child focus of parental delusions etc …	Thank you for your comment. The scope of this guidance does not allow us to look at risk factors in the parent(s).
SH	Alder Hey Children's NHS Foundation Trust	19	Full	General		Important to recognise that maltreated children may not show emotional or behavioural disturbances. The absence of supporting emotional and behavioural difficulties does not preclude that maltreatment is ongoing.	Thank you for this comment. Indeed this is true. The GDG believes that by raising awareness of individual physical indicators, the situation you mention is accounted for.
SH	Alder Hey Children's NHS Foundation Trust	20	Full	General		On balance the guidelines are very clear and helpful in terms of providing an overview of literature and clear pathway for considering and weighing up information.	Thank you.
SH	Association for Family Therapy and Systemic Practice (AFT)	1	General			NICE deleted Introduction as in text box.	No response required.
SH	Association for Family Therapy and	2	Full	Glossary	12	Definition of 'Cognition' should include 'knowing' – the Oxford dictionary defines cognition as 'the faculty of knowing'	Thank you. This change has been made.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Systemic Practice (AFT)						
SH	Association for Family Therapy and Systemic Practice (AFT)	3	Full	3.1	32	There may also be doubts about the standard of state substitute care	Thank you for your comment. Where appropriate, we have replaced parent with "parent or carer" in recommendations to account for this.
SH	Association for Family Therapy and Systemic Practice (AFT)	4	Full	3.1	32	There is often a belief that a child who is removed from an abusive or neglectful family could be immune from abuse in substitute care, whether this is in kinship care or an adoptive family.	Thank you for your comment. Where appropriate, we have replaced parent with "parent or carer" in recommendations to account for this.
SH	Association for Improvements in the Maternity Services (AIMS)	1	Full	1.1.	14	We do not doubt that there are abused and neglected children who are not on the register and should be. But registration rates vary greatly over time, and by local authority, and are affected by style of social work practice (eg intensive and high quality early investigation may reduce the need for registration).*(1)* The necessity for some registrations is hotly disputed by parents - and some are subsequently supported by the courts.(e.g. Leeds City Council v Mrs YX [2008] EWHC (Fam)14 March 2008) It would be more acceptable to acknowledge that there are inaccuracies in both directions, though there is less evidence of over-registration. Whilst there have been surveys of adults asking about previous experiences of child abuse, we know of no similar surveys about unwanted or damaging child protection intervention they	Thank you for your comment. While there may be inaccuracies, we have cited national statistics. It is not within the remit of this guideline to explore the quality of the child protection system. For information, we have updated this section with figures from 2008.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						experienced. *(1) H Ward, L Holmes, J Soper, Costs and consequences of placing children in care. Jessica Kingsley 2008.*	
SH	Association for Improvements in the Maternity Services (AIMS)	2	Full	2.1	20	We welcome the emphasis on professionals recording "exactly what they see and hear" rather than an interpretation of it.	Thank you. In light of other comments, this has been amended to: "record on the child or young person's clinical record exactly what is observed and heard from whom and when".
SH	Association for Improvements in the Maternity Services (AIMS)	3	Full	3.1	32	The guidance has been developed "in order to help healthcare professionals overcome some of the obstacles", which include (line 10) the discomfort of disbelieving or wrongly suspecting parents, (line 15) the uncertainty about when to mention suspicion and what to say to parents and what to write in the file and (line 17) losing control over the child protection process and doubts about the benefits thereof. This last point is not surprising since there is virtually no evidence-base for benefit in many current child protection interventions and procedures. There is, for example, evidence of damaging style of practice in social workers who used a confrontational and aggressive approach "so consistently observed that it is likely to be a systemic issue" *(1),* multiple adverse outcomes, from a large randomised controlled trial of over 5,000 families allocated to standard or an alternative supportive social work response (after children at immediate and serious risk were excluded), with long term follow up, in Minnesota *(2) (3)* Even allowing	Thank you for your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						for transatlantic differences in welfare provision, it has widespread implications for the UK . The fact that these intellectual and unethical discomforts exist in the minds of many clinicians is a credit to them. These are crucial issues of importance to consumers also, yet the guide ploughs on with the assumption that "firmer" evidence and formal guidelines on diagnosis will enable the professional to ride roughshod over his or her doubts. The mere mention of these practical and ethical difficulties does not abolish them *(1) D.. Forrester et al. How do child and family social workers talk to parents about child welfare issues? Child Abuse Review 17(1): 23-5 2008* *(2)) Loman L.A.& Siegel G.S. Minnesota Alternative Response Evaluation Final Report. Executive Summary. Institute of Applied Research St Louis Missouri 2004* *(3) Institute of Applied Research St. Louis Missouri. Extended Follow-up study of Minnesota's Family Assessment Response. Final Report. Conducted for the Minnesota Department of Human Services 2006.*	
SH	Association for Improvements in the Maternity Services (AIMS)	5	Full	3.1	32	Line 34 mentions the risk factor of "previous unexplained death of a child within a family." We deal with many parents who have unexplained miscarriages, stillbirths and neonatal deaths. This may affect the behaviour of parents with existing or later children in different ways, and the behaviour of siblings, as well as their interaction with services, and	Thank you for raising this. We have removed this phrase at your suggestion.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						we have seen many such families. The emotional fall-out from this loss - its duration and severity, and different methods of coping by different family members, - is frequently under-estimated. Unresolved questions about quality of care of the dead child occasionally leave parents rather hostile to, and questioning of, care-givers. It can also make them anxious (we do not label it "over-anxious") if a child is sick. They may take children to the doctor more often or insist on more investigation. In our long experience this used to be dealt with sympathetically, particularly by G.P.s Nowadays it can lead to unfounded suspicion of F.I.I. or allegations that they do not cooperate well with professionals To emphasise previous bereavement as a source of suspicion can create further damage unless it is accompanied by further explanatory text. This applies to many other aspects of this guideline.	
SH	Association for Improvements in the Maternity Services (AIMS)	6	Full	4	21	line 26: Bruising in babies who are not independently mobile. We have had a number of complaints from indignant parents in this situation, where a bruise in a young baby is considered not *a cause to suspect* abuse but *virtual proof* of abuse. Often they believe the bruise was cause by a projection on baby equipment, and demonstrate how this may be so. Others say they are totally mystified. This seems to be one of the signs which professionals often jump on with certainty, despite other signs of loved and well cared-for children. *There is a need to explore what*	Thank you. This document offers guidance about when to suspect maltreatment, not how to diagnose or confirm maltreatment. The GDG believes that its recommendations encourage health professionals to rule out innocent causes of bruises before suspecting maltreatment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						innocent causes there may be for immobile infants having bruises.	
SH	Association for Improvements in the Maternity Services (AIMS)	*7*	Full	2.1	21	*Bites. "Abuse is suspected when t here is report or appearance of a bite mark caused by an adult "* If the bite comes from an under-16 year old, is abuse no longer to be suspected? We seem to be receiving an increasing number of reports from parents of violence of many kinds, emotional abuse and sexual interference, from other children - usually while at school. . (And this is causing them to keep children at home) This violence equally is maltreatment, and it should be recognized and acknowledged as such, although the remedies may be different. The aim surely is to protect children,(both abusers and abused) not merely to find an parent or carer to blame.	Thank you. The point is well taken that an abuser does not have to be an adult in all circumstances. The GDG has decided to replace "suspected to be caused by an adult" with "that is thought unlikely to have been caused by a young child". We hope this change is helpful.
SH	Association for Improvements in the Maternity Services (AIMS)	8	Full	2.1	*22*	re Fractures (lines 28-31 and Intra Cranial Injuries. We have noticed that accounts of being falsely accused often come from parents of premature babies of infants with a history of difficult labour/instrumental deliveries. Many have been in SCBUs. A number of parents have suggested that these could be problems arising from birth or neonatal treatment. Official assumption is often that children have been harmed by parents because of lack of bonding caused by separation in SCBU, or provocation caused by caring for a difficult baby. But parents raise the question of birth or neonatal injury in hospital. We have been	Thank you for the comment. There are research studies on newborns that routinely look at MRI brain scans, namely those from the Sheffield group. The characteristics of fractures in preterm babies represent an area that needs to be explored. This is a related field and is broadly addressed in research recommendations of a prospective study of fracture patterns in preschool children.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						unable to trace any brain imaging studies of a population of such children on discharge. We suggest this should be added to the list of future research projects. The literature describes both fractures and brain damage inflicted by physiotherapy on premature babies and the cause was at first withheld from publication.The history was summarised in our Journal*(1)(2)(3)* "Had the fractures of this unintentionally battered neonate first been diagnosed following hospital discharge, he might have been labelled as a case of parental child abuse." wrote (4) And although such cases are uncommon, we do receive accounts from parents who saw their baby dropped by staff, or were told by other parents or staff that it had happened. These incidents are often not recorded on case notes. Presumably it also happens in cases where parents did not know of it. *(1) J Robinson. Shaken baby syndrome caused by hospital care. AIMS Journal Spring 2003 Vol 15 no 1* *(2) J Harding et al. Chest physiotherapy may be associated with brain damage in extremely premature infants. J. Pediatr, 1997 132: 440-4* *(3) H Cull et al. Inquiry into the provision of chest physiotherapy treatment provided to pre-term babies at National Women's Hospital between April 1993 and December 1994. Ministry of Health, Wellington, 1999* *(4) D Purohit et al Multiple rib fractures due to physiotherapy in a neonate with hyaline membrane disease Am J Dis Child 1975*	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						120:1103-4	
SH	Association for Improvements in the Maternity Services (AIMS)	9	Full	2.1	23	line 12 "Delay in presentation". Increasingly we are finding that promptness in seeking advice, and willingness to do so is affected by parents' experiences of how they were treated in the past. Even the most short-lived episode of suspicion, or investigation experienced by them, their relatives, neighbours or friends. , may have profound effects on future interactions. Delay can be caused by fear, and should be treated with a sympathetic approach to mend fences rather than more suspicion. Increasingly authoritarian and suspicious approaches by doctors, midwives, health visitors, etc. are driving parents into the hands of alternative practitioners. And of course any previous suspicion of MSBP or FII , even if disproved, makes parents afraid to consult at all - for themselves as well as their children, and we have seen many such cases.	Thank you for your comment.
SH	Association for Improvements in the Maternity Services (AIMS)	10	Full	2.1	23	Line 13 "Absent, implausible, inadequate or inconsistent explanation". There can be many innocent reasons - for example if parents' accounts differ from records, the records are not invariably correct. The fear we have mentioned in (9) above is also leading parents to edit their accounts to professionals for fear of being misunderstood, as they frequently tell us. This seems to be affecting even parents who have had no previous experience of suspicions or accusations. After all, we receive so many accounts from	Thank you for your comment. An adequate explanation constitutes a suitable explanation and therefore no reason to suspect maltreatment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						parents of "inadequate and inconsistent" explanations from professionals, there should be some under standing that the fallibility of communication in clinics might be given more understanding.	
SH	Association for Improvements in the Maternity Services (AIMS)	11	Full	2.1	24	Line 31-33. Neglect "Healthcare professions should consider neglect if parents persistently fail to engage with current preventive child health promotion programmes, for example health and development reviews, screening and considering advice about immunisation, feeding, diet, exercise and injury prevention." A) We profoundly object to this catch-all which will undoubtedly by used - as such concepts are already being used - to control anyone whose style of parenting is different, and who does not accept the advice and policies outlined by their local health visitor, GP etc. but is nevertheless an affectionate, caring and thoughtful parent. Indeed it is those who are willing to challenge orthodoxy, who are most being submitted to threats and control. We have seen years of this with women who wanted home births, and we still do. We are increasingly seeing threats of child protection being used against parents who merely question treatment or recommendations- and it is turning them away from orthodox care. B) Immunisation is included despite the fact that the evidence quoted for any association with neglect (only one study - M Stockwell et al - with a biassed sample done in a country with a different public health system and was found inadequate by your own standards for	Thank you for your comments. The GDG have carefully reconsidered this issue and their considerations can be found in the full version of the guideline. For information, this recommendation has been changed to: "Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include: immunisation, health and development reviews, screening." Please note that these indications are supported by a process – as outlined in the section on how to use this guidance. The guideline aims to support the NHS, parents and cares in the recognition of signs and symptoms that may lead to identification of child maltreatment D) This refers to situations that are outside the scope of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						evidence . This is unacceptable C) Parents "failure to engage" can be, and often is, caused by a service style, location, , treatment, or authoritarian personnel they do not find acceptable. *All "opting out" should be examined in the context of the NHS Trust being a monopoly provider - unlike health services in many countries where users have a choice.* D) Women are failing to cooperate with screening for postnatal depression because the consequences (referral to social services and temporary or permanent loss of their children) is a greater risk than untreated disease (*1)* *(1)* *E)* We know older parents who failed to act on with confident advice from doctors, midwives and health visitors to place their babies to sleep face down - well-meant advice which killed thousands of babies throughout the developed world. Possibly some of those children survived as a result. We have lost count of the complaints we have had from mothers advised by health visitors and G.P.s to stop breast feeding - but they ignored it and carried on because they believed in the benefits of breastfeeding. Who is to say what current orthodoxies will be changed in the near future?	
SH	Association for Improvement	12	Full	2.1	24	Line 41-42 "Should consider neglect if parents or carers persistently fail to attend follow-up outpatient appointments...that are essential to	Thank you for your comment. We agree that reasons for non-attendance are indeed complex. The chapter on neglect highlights in

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	s in the Maternity Services (AIMS)					child's health and wellbeing." Our problem with this is that, once again, it is not set within a context of other possible causes being explored first. Parents, children and professionals may legitimately differ in their assessment of how "essential" an attendance is, and whether it is, in fact, likely to improve wellbeing. Some children tell us this too, and can be emphatic. Lay assessments of quality and outcomes of care are not necessarily always wrong. Failure to listen to concerns about side-effects of medication, or differing views, can put families in the position that they feel their only way to prevent browbeating or confrontation and is avoidance of contact. We have much experience of this from antenatal care. Reasons for non-attendance are complex, and there are a number of studies on causes of which many professionals seem unaware e.g. Birmingham found parents usually made conscious decisions balancing advantages and disadvantages of follow-up appointments , some said the reasons had not been made clear, or the children had now improved.*(1)* Failure to attend follow up child psychiatry appointments "may be due to child or parent dissatisfaction with the first appointment" and children themselves refusing *(2)* In our experience appointments may be missed because of (a) transport problems and costs, especially in poorer families, (b) the service or personnel may not be helpful in their experience - and can even be seen as	the introduction a context in which there appears to be a disregard for the child's needs. Text has been added to support the recommendation to show that the absence of legitimate reasons for non attendance is an important marker that should not be ignored.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						toxic.(something the clinical notes are unlikely to record) (d) illness in the carer These problems should always be explored before labels like "neglect" are considered. In the Confidential Enquiries into Maternal Deaths Dr. Gwyneth Lewis has pointed out that if people in high risk groups do not use a service, it is the duty of the service to change, to meet their needs, rather than blaming non-attenders. *(3)* Our concern is heightened by seeing non-attendance used not as a means of identifying genuine neglect, but as a weapon against families who are disapproved of for other reasons (often for having made an earlier complaint about quality of care) A social work lecturer describes how his students "spend their days plugging information about failed appointments into a software package developed for a business environment. This amassed information can then be used to establish the pattern of non-compliance necessary to justify heavier interventions" (4) We even have cases where this has occurred where parents insist they had never been told of the appointments, and we have supporting evidence of deliberate misinformation in one case. *(1) R Andrews et al. Understanding non-attendance in outpatient paediatric clinics Arch. Dis. Child. 65 (2) 192-5 1990* *(2) S El-Badri & P McArdle Attendance at child psychiatric clinics. Psychiatric Bulletin 22 554-6 1998* *(3) Gwyneth Lewis. Why Mothers Die 2000-*	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						2002. RC0G 2005 *(4) Mark Smith Loving or fearful relationships* *http://www.goodenoughcaring.com/JournalArticle.aspx?cpid=52*	
SH	Association for Improvements in the Maternity Services (AIMS)	13	Full	7	26	*Emotional, behavioural and interpersonal social functioning. Lines 26-29 Please note the symptoms here described are also related to us by parents, in both themselves and their children, as a result of* child protection interventions. We have seen a number of cases where problems which become apparent in foster care are automatically attributed to previous treatment by birth parents, whereas they arise as a result of maltreatment in the new location. A recent example in our files was attempted rape by the older son of a foster care. Previous complaints by the mother, and the child, had been disbelieved, and only a serious suicide attempt by the child established the truth. *May we plead for an open mind on the sources of maltreatment of children in care. In our experience there is a tendency to deny that there is a problem at all or to record it as of lesser severity, if it occurs in a local authority placement. In our experience problems are covered up, downplayed, or detected later than they should be.*	Thank you for your comments. While it is recognised that this may be the case for children well into the investigation process, this document is aimed at front-line health care professionals who may be seeing the child for the first time in some cases. We also hope that should a health professional who has seen any child regularly note any obvious change in the child's behaviour or demeanour then they will also refer to this guidance. This guideline is a tool for health professionals to assist in their choices once observations have been made. It is hoped that the guideline will be used before any investigation is underway.
SH	Association for Improvement	*14*	Full	7	26	Lines 36-39 We are delighted that this section mentions the need to explore ADHD, autism spectrum disorders and bipolar disorder before	Thank you for these comments, but the issue of training child care professionals in the identification of developmental disorders lies

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	s in the Maternity Services (AIMS)					considering child maltreatment if a child shows repeated, extreme or emotional proportion to which they are not expected. This is one of the too few sections where the need to exclude alternative diagnoses is given a mention - albeit brief. May we point out that the symptoms listed do not cover the range of behaviours which may be seen in such children, and there is widespread ignorance of these in health visitors, doctors, teachers, social workers, so diagnosis may be made much later than it should be. If only the same educational input for all professions had been applied for training in picking up signs of these increasingly common and serious problems, as has been used for MSBP and FII (an uncommon problem) many parents and children would have benefited. This is ADHD, autism, etc should be mentioned in other sections of the Guideline also (eg absence from school)	outside the remit of the GDG's responsibility and the GDG strived throughout to emphasise the need to consider alternative explanations for children's emotional and behavioural presentation.
SH	Association for Improvements in the Maternity Services (AIMS)	15	Full	2.1	25	Lines 1-3 "Healthcare professionals should *suspect* (our italics) neglect if they encounter.....living space that is inappropriate or unsafe for the child's developmental stage." We object most strongly. This might well be appropriate if we were talking of neglect by the local authority, the government, or private landlords. It is obvious that many families have to live in cramped and poor housing, and we have never encountered a parent who did not want something better. We cannot understand why	Thank you for your comment. We have amended this recommendation to show that factors should be within the parents control to exclude the issue you raise. We have also added some contextual text to this recommendation.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						quality of housing should cause suspicion. This is largely associated with poverty and shortage of public housing, and there is no evidence that this is associated with neglect.	
SH	Association for Improvements in the Maternity Services (AIMS)	16	Full	2.1	25	Lines 5-6 Over-and under-nutrition "Healthcare professionals should consider child maltreatment in *any* (our emphasis) with abnormal growth patterns for which there is no medical cause." We profoundly object to this statement, and believe it can only be damaging to cooperation with public health and educational measures. Whilst many possible medical causes and social causes of under-nutrition have been fairly well researched and understood, the move to include obesity as a catch-all fills us with concern. We have seen cases (and have actually observed interactions with professions) in cases where childhood obesity was included as a neglect issue by social services, and the effects were damaging to the children and families concerned. We have also seen totally wrong and harmful advice on changing nutrition from social workers and child contact centres. The RCPCH issued a press release in June 2007 saying that childhood obesity was primarily a public health problem, not a child protection issue, but there may be a few families where there might be discussions with social services. Once neglect is on the agenda, parents perceive changes in professionals' manner towards	Thank you for your comment. This recommendation has been removed.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						them, and we have seen many times how this prevents constructive care. The self-esteem of obese children is often already low, and threats of removal or court proceedings - which is their fault for drinking fizzy drinks or eating crisps - could have long term harmful impact. We know obesity is a health problem, but there is as yet too little evidence on effectiveness of interventions to encourage wider inclusion of obesity under a label of neglect.	
SH	Association for Improvements in the Maternity Services (AIMS)	17	Full	General	General	Alternative diagnoses. We deplore the failure to set each problem within a context of possible alternative diagnoses and explanations for symptoms. Although many doctors will be aware of these, other groups, like social workers, are more likely to interpret suspicion as something firmer, and without the qualifications attached by the original diagnostician. This affects observation of data, what is recorded and how, and any action by the parent - however innocent - is likely to be interpreted to fit. (This applies particularly to FII) Their comments then feed into the multi-agency circulation, resulting in a misleading multiplier effect.	Thank you for this comment. Our operational definition of 'consider' allows for a whole assessment of the child and the indicators that fall in the 'suspect' category are indeed indicators of clinical suspicion and not proof or diagnosis of maltreatment. We therefore agree with your implication that indications may have an innocent explanation and expect professionals to consider them alongside possible maltreatment.
SH	Association for Improvements in the Maternity Services	18	Full	General	General	Interpreting statistics Statistical statements such as "obese children are x times more likely to suffer neglect" are not understood by many who will use the guidelines, eg social workers and health visitors, including some doctors - and family courts. They do not understand	Thank you for your comment. A Quick Reference Guide that contains a summary of all of the recommendations is being produced. This guide will be written in plain English. Statistical statements are required in the full guideline in order to represent the research

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	(AIMS)					that while neglect may be more common in one group, the vast majority of obese children are not neglected.	that underpins the recommendations.
SH	Association for Improvements in the Maternity Services (AIMS)	19	Full	General	General	Poverty Many of the problems listed are strongly related to social class. Poverty is associated with homelessness, poor housing, prematurity, higher infant and child mortality, SID, dental caries, obesity, lack of private transport, etc. There is too little acknowledgement of this. Not all research on maltreatment and neglect control adequately for social class, and in practice we find parents being accused of neglect when they have the same problems as most of their neighbours on the estate. The remedies lie outside changes in parenting. In fact we often find cause for respect and congratulation in what many parents have managed to achieve in spite of their circumstances. Surely the aim is to help children to flourish, rather than police and control the poor?	Thank you for this comment. The indicators of neglect are not indicators of poverty.
SH	Association for Improvements in the Maternity Services (AIMS)	20	Full	General	General	Lack of confidence in services Although we have made many criticisms, we appreciate that this guideline is trying to help professionals to do a difficult job, and we are just as concerned as they are to protect children. But we are very concerned at the increasing number of cases where parents describe their lack of confidence in professionals, their fear of paediatricians or visiting A & E, the unacceptability of health visitors whom they see as "the health police" etc. Distinctions between "suspect" and "consider" may involve fine distinctions which mean	Thank you for your comment. The scope for this guidance does not extend to professionals' behaviour. It aims to support professionals in their decision making and early recognition of families who need help.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						different things to groups with different professional training, and there is also a wide variety of assessment between professionals. It only takes one professional in the large multi-disciplinary network to behave in a harsh, bossy, authoritarian, etc. manner, to taint the whole package in the parents' eyes. The ripples of false-positive or badly-handled diagnoses extend widely Parents telephone us and describe injuries or illnesses in their children which they would formerly not have hesitated to take to the doctor or hospital. Now they are afraid to do so. They are also afraid to be open in describing symptoms or histories in their children or themselves. Many of these parents have had previous brushes with some allegation or suggestion of abuse or neglect of children (sometimes minor) Sometimes they were not openly stated but they could tell by changes in the behaviour of doctors, or nurses on the ward, what was afoot. Others quote relatives' or friends' experience. Increasingly there are others with no direct experience but which seem to be part of the general community feeling. It is for this reason that in the earlier scope we emphasised the need for acknowledgement of what was happening, and attention paid to the way in which episodes of suspicion are dealt with. Anything which affects basic confidence in paediatrics and child health care services is a	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						serious issue.	
SH	Association of Child Psychotherapists	1	NICE	General	General	The ACP welcomes this guidance to support and orient healthcare professionals in the challenging area of child maltreatment. As indicated in our general and specific comments below, the ACP believes that this guideline can play a significant and much-needed role in drawing attention to possible deterrents to recognising and responding to concerns about child maltreatment and the challenges faced by healthcare professionals whose work focuses on engaging difficult or hard to reach parents and carers.	Thank you for commenting on this draft.
SH	Association of Child Psychotherapists	2	NICE	General	General	In addition to our specific responses under the headings below, we wish to make three general points: 1. The experience of child and adolescent psychotherapists indicates that health professionals value guidance about the specific needs of babies, children and adolescents to help guide them as to what to look for and when to intervene. **a) Babies and pre-school children** The vulnerability of **babies** and young children to emotional as well as physical neglect and abuse needs to be highlighted. It may be particularly difficult for healthcare professionals to recognise and respond to maltreatment of babies and young infant. Belief remains widespread that babies are not affected by emotional neglect or abuse or, for example, by witnessing domestic violence, despite robust	Thank you for your comments. 1a) We have highlighted infants in our recommendations about emotional neglect and added a sentence in our GDG considerations to the effect that infants are more vulnerable to the effects of emotional neglect. This guidance can only deal with maltreatment that is likely to be suspected by health professionals.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						and extensive evidence from developmental, neurological and attachment research that, on the contrary, children are most vulnerable to the effects of emotional neglect and abuse in their first year of life. Healthcare professionals should be aware that **pre-school aged children** are at greater risk of undetected maltreatment because they are not necessarily seen on a daily basis by people beyond their immediate families. Nearly 50% of serious injuries or fatalities as a result of maltreatment are to infants under one year of age. With this age group, professionals should be particularly proactive in communicating their concerns to colleagues within and outside the service; especially when it is not clear who is living/staying in the family home. **b) Older adolescents** Healthcare professionals should also be aware of the needs of **older adolescent children** who may be very difficult to help. These emerged powerfully in Analysing Child Deaths and Serious Injury through abuse and neglect: What can we learn? A biennial analysis of serious case reviews 2003 – 2005 (DCSF, January 2008). Many 'hard to help' young people from of 11 have long histories of involvement with children's social care and other specialist agencies. Over time, 'professional fatigue' can set in, leading agencies to run out of helping strategies and	b) This guidance only deals with child protection, not safeguarding.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						become reluctant to continue to follow up suspicions of maltreatment. As a result, the needs of this age group are often 'neglected', repeating patterns of earlier neglect in the family. 2. Child and adolescent psychotherapists' experience is that the emotional, psychological, and psychosocial features of maltreatment need clear highlighting for healthcare professionals. Healthcare professionals should be aware of general trends in the incidence of maltreatment. As well as looking for indicators in the individual child, health professionals should be aware of the need for the child to be looked at within the context of the family and family relationships. 3. Healthcare professionals should also be aware of chronic and cumulative features of maltreatment in addition to acute features (see also comment 5 on Section 1.2.1).	2. The GDG has made its best efforts to draw health professionals' attention to the emotional and psychological indicators of maltreatment. It has also highlighted harmful parent/carer-child interactions. 3. The GDG has aimed to represent all clinical features of maltreatment that would lead a professional to be concerned. This includes chronic and cumulative features where appropriate.
SH	Association of Child Psychotherapists	3	NICE	**Communicating with and about the child or young person.**	6	Healthcare professionals should be aware that psychological factors may powerfully deter children from disclosing maltreatment, or impede professionals from recognising and responding to maltreatment (see also comment 10 on section 1.2.7 - point 1 Deterrents in the child and point 3 Deterrents in the health professional).	Thank you for your comment. This is not within the scope of this guidance.
SH	Association	4	NICE	1.2.1	8	In addition to these indicators, healthcare	Thank you for this helpful suggestion. The

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	of Child Psychotherapists					professionals should suspect child maltreatment when they are concerned about a child and parents or carers refuse permission for them to see the child face-to-face or talk to them alone; or when parents are so hostile that professionals feel intimidated in carrying out their professional roles (see also comment 10 on section 1.2.7 - point 3 and comment 19 on section 1.7).	GDG agrees and proposes the following: 'Consider child maltreatment if a parent or carer refuses to allow a child or young person the opportunity to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.'
SH	Association of Child Psychotherapists	5	NICE	1.2.1	8	Healthcare professionals should also be aware of chronic or cumulative presentations of maltreatment. For example they should be as alert to the possibility of maltreatment in a child who repeatedly presents at hospital with less serious injuries as in one that presents in acute crisis.	Thank you for this comment. This issue is addressed in the later recommendation about frequent presentations or reports of injuries.
SH	Association of Child Psychotherapists	6	NICE	1.2.1	8	Health care professionals should be aware of chronic developmental problems stemming from maltreatment.	Thank you for this comment. The GDG has aimed to represent all clinical features of maltreatment that would lead a professional to be concerned. This includes chronic and cumulative features.
SH	Association of Child Psychotherapists	7	NICE	1.2.1	8	Further assessment should be sought when it is not clear whether a child's physical or emotional symptoms are caused by organic illness or neurological disorder, or by maltreatment, or are co-morbid.	Thank you for your comment. This is implicit in the actions associated with 'considering' maltreatment.
SH	Association of Child Psychotherapists	8	NICE	1.2.1	8	Healthcare professionals should consider maltreatment when several factors known to be co-morbid with maltreatment of children are present, such as: • Known parental substance misuse • Known mental health difficulties in	Thank you for this suggestion. The scope of this guidance does not permit us to discuss factors in the parents or risk factors.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						parent(s) • Incomplete history or many changes of address (may indicate historical maltreatment) • Evidence, whether in the past or present, of injury to the caregiver: children in families where there is known or suspected domestic violence are more likely to be victims of violence themselves • Highly conflicting or unusually disturbing responses to observations or expressions of concern about a child.	
SH	Association of Child Psychotherapists	9	NICE	1.2.1	8	Healthcare professionals should be aware that pre-school aged children are at greater risk of undetected maltreatment because they are not necessarily seen on a daily basis by people beyond their immediate families. With this age group, professionals should be particularly proactive in communicating their concerns to colleagues within and outside the service (see also comment 2 general – point 1).	Thank you for this comment. The GDG's view is that the recommendations will encourage health professionals to engage with colleagues for children of all ages. Age as a risk factor is addressed where appropriate in the recommendations about specific indicators of maltreatment.
SH	Association of Child Psychotherapists	10	NICE	1.2.7	9	This guidance on possible deterrents to recognising and responding to concerns about child maltreatment is of paramount importance. In addition to those listed, we suggest the specific indications listed below: **1. Deterrents in the child** Healthcare professionals need to be aware of the powerful loyalties that children and young people often feel towards their parents or carers, even when they are abusive or	Thank you for your detailed comments. The GDG is keen to highlight barriers in health professionals to recognising maltreatment. Deterrents in the child are outside the scope of the guidance because this guidance is only concerned with what is observed in the child. All of the deterrents in the parent/carer that you mention are risk factors for maltreatment, which are outside the scope of the guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						neglectful. A particularly strong or intense attachment between a child and their parent(s) or carer(s) should not in itself be assumed to be one that is in the child's best interests or promotes the child's healthy development. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that children may be frightened or confused by parents or carers who have mental health or personality difficulties. **2. Deterrents in the parent/carer** Healthcare professionals should be alert to the possibility of maltreatment when a parent or carer refuses them permission to see a child face-to-face or talk to a child alone. Concern should also be raised when curiosity or worry about a child's behaviour, appearance or emotional or physical presentation is met with a level of hostility that makes the professional feel intimidated in carrying out their role. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that they themselves feel frightened or confused by parents or carers who have mental health or personality difficulties. Healthcare professionals and their managers should be aware that some parents or carers with mental health or personality difficulties	The deterrents in the health professionals that you mention are covered in our list.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						may be helped by support from family or friends, parenting support, training, or their own therapy, while others are not able to make use of help, or are not able to do so 'within the child's timescales'. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that parents or carers may be so needy and vulnerable in themselves that they cannot have adequate insight into features of maltreatment in their care of their children. Healthcare professionals should be aware that in severe cases of child maltreatment, perpetrators are likely to be highly motivated to escape detection, and may be highly skilled in manipulating professionals, creating confusion, and evading professional concern, as well as the concern of friends, family and neighbours. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that parents or carers may be dangerous, or manipulative, or may have mental health difficulties that make contact with them unpredictable, frightening or confusing. **3. Deterrents in the healthcare professional** Fear of hostility from parents or more general anxieties about raising the prospect of abuse and/or interfering with the structure of a family can propel healthcare professionals into	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						unwittingly overlooking clearly-presented features of child maltreatment. Other contributory factors may include powerful denial on the part of a parent/carer; a lack of support structures in which to raise concerns; action-oriented workplace cultures which discourage reflection and reflective practice. Healthcare professionals' concentration on a specific remit, for example, to engage 'hard to reach' parents or carers, may inadvertently lead them to lose sight of the needs of the children. Healthcare professionals should liaise with senior colleagues and/or a named professional for safeguarding children when they are concerned that childrens' need for protection may outweigh professional priorities to engage parents. See also: comment 3 and comment 19.	
SH	Association of Child Psychotherapists	11	NICE	1.2.8	9	Support for healthcare professionals and liaison/consultation with mental health services are crucial to maintain professionals' capacities to recognise and respond to signs of maltreatment. A culture of open questioning, reflection and sharing of anxiety can help to overcome psychological barriers to raising the prospect of child maltreatment.	Thank you for your comment. We will pass it on to the implementation team at NICE.
SH	Association of Child Psychotherapists	13	NICE	1.6	22-26	The ACP welcomes the focus in 1.6 on emotional indicators, in addition to the physical indicators listed at 1.3, 1.4 and 1.5. In addition to the emotional indicators detailed at 1.6, healthcare professionals should	Thank you for these suggestions for additional features. Some of them have been included, albeit in slightly different wording among the examples selected by the GDG in a list which is not exhaustive.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						consider the possibility of maltreatment when a child persistent ly shows emotional flatness, listlessness, lack of interest in others or surroundings, indiscriminate attachment, marked neediness, hypervigilance, emotional dysregulation and/or childhood depression.	
SH	Association of Child Psychotherapists	14	NICE	1.6	22-26	**Babies**: Special attention should be paid to presentations of maltreatment in babies including failure to thrive/faltering growth, lifeless reactions, persistently avoiding eye contact or face to face interaction with parents or carers and a lack of responsiveness. Healthcare professionals should consider the possibility of neglect when babies' interactions with their parents or carers are persistently avoidant or bizarre and disturbing (see also comment 18 on section 1.7). Nearly 50% of serious injuries or fatalities as a result of maltreatment are to infants under one year of age (see also comment 2, point 1).	Thank you for your comment. We have highlighted infants in our recommendations about emotional neglect and added a sentence in our GDG considerations to the effect that infants are more vulnerable to the effects of emotional neglect. The vulnerability of infants and young children to injuries are referred to in the recommendations on the respective injuries
SH	Association of Child Psychotherapists	15	NICE	1.6	22-26	Healthcare professionals should consider the possibility of maltreatment when children's interactions with peers, teachers or other adults involve coercive controlling, pronounced aggression or emotional dysregulation.	Thank you for your comment. Aggression or emotional dysregulation have been included, albeit using slightly different wording. Coercive controlling behaviour towards parents or carers has been added to the list of examples in this recommendation.
SH	Association of Child Psychotherapists	16	NICE	1.6	22-26	In addition to "marked changes" (1.6.1) in behaviour or emotional state, healthcare professionals should as alert to the possibility of chronic, cumulative maltreatment in a baby or child with chronic emotional or behavioural difficulties (as per comment 2 - point 3 and	Thank you for your comment. The GDG believes that these aspects have been included in 1.4.2

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						comment 5).	
SH	Association of Child Psychotherapists	17	NICE	1.6.11	25	Secondary day or night time wetting in the absence of medical causes could be understood as a communication of distress or a response to loss instead of or as well as a possible indication of maltreatment.	Thank you for your comment.
SH	Association of Child Psychotherapists	18	NICE	1.7	26	We welcome the thorough attention that has been paid to the psychological aspects of emotional abuse in this section and the recognition that healthcare professionals should be aware of the emotional quality and context of parent-child interactions. In addition to the bullet points raised at 1.7.1, healthcare professionals should consider the possibility of emotional abuse when: • babies' or children's interactions with their parents or carers are persistently avoidant or bizarre and disturbing (as per comment 14 on section 1.6); • a baby or young infant persistently avoids interaction or eye contact with parents or carers, freezes or dissociates, has persistent rigid muscle tone, or is lifeless or listless in the presence of parents but shows extreme indiscriminate, excited responses to strangers. We feel that the fourth bullet point at 1.7.1, 'using the child for the fulfilment of the parents' needs, for example, children being used in marital disputes', needs further clarification.	Thank you for your comment. The items you mention in your bullet points are covered above in 'Emotional, behavioural and interpersonal/social functioning'. The complexities you refer to in your last point are too detailed for the purposes of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Children are often caught up in marital breakdown in complex ways when parental communication breaks down. In our view, it could be considered emotional abuse when, during marital conflict, a child is used by one parent against the other.	
SH	Association of Child Psychotherapists	19	NICE	1.7	26	Healthcare professionals should also be aware of the parents' style of interaction with professionals, which may provide pointers to the child's experience of the parents and may indicate difficulties in the parent that result in maltreatment. Professionals should be on the alert when they experience unusually extreme emotional reactions, for example strong feelings of discomfort or high levels of anxiety (as per comments 3, 4 and 10).	Thank you for your comment. You have identified a feature that is that is independent of the child and as such outside the scope of this guidance.
SH	Association of Child Psychotherapists	20	NICE	1.7.2	27	As well as being alert to the possibility of emotional neglect, healthcare professionals should also be aware of the possibility of maternal depression in a parent who is emotionally unavailable and/or unresponsive.	Thank you for your comment. Unfortunately, it is outside the scope of this guidance to address parental illness.
SH	Breastfeeding Network	1	NICE	General		Thank you for the opportunity to comment on this draft guideline. We welcome a guideline for health professionals in this area. As a general point we welcome the idea that this guideline is to prompt health professionals to "think about the possibility of maltreatment and to raise awareness." We feel that this will need a lot of emphasis when promoting and implementing the finished guideline and is not interpreted or seen by health care professionals to mean "always suspect child maltreatment when……" which we feel is a	Thank you for commenting on this draft guidance. The GDG agrees with your sentiment. Distinguishing between consider and suspect will enable health professionals to differentiate between features. Further to your suggestion, the UN Convention on the Rights of the Child has been cited in the introductory text.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						risk. This comment is based on the feeling that in isolation some of the presenting features would not be a cause for concern and are a normal healthy part of growing up and learning about how the world works. The United Nations Convention on the Rights of the Child (UNCRC), which the UK Government has signed up to, should be mentioned in this guidance.	
SH	Breastfeeding Network	2	NICE	1.1.2	7 & 8	Good to see suggestions for what action will need to be taken and that "no further action" is not an option. We hope that any extra work involved on the part of the health professional involved does not detract from providing the actual care for the child. The Government will need to ensure that there is extra resources and funding available for this to be safely implemented. We would like to see included in the action plan the need for referral to other disciplines, as necessary. Not every health professional may be aware that there could be a medical cause for the presenting 'symptom' or 'injury'. One example would be where a baby presented at clinic and had not gained enough weight according to the growth charts. There may be a medical cause for this and this	Thank you for your comment. The GDG agrees that implementation of this guidance has consequences for agencies outside the NHS. Specific referral to other disciplines is outside the scope of the guidance but 'considering' maltreatment allows for a medical explanation to be sought by a specialist other than the professional to whom the child initially presents. Service provision is also outside the scope of the guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						should be ruled out before maltreatment is suspected. In addition part of the action plan should be to involve the voluntary sector in providing help and support for the parent or carer. This would complement what is being provided by the health service. Organisations such as ours (the Breastfeeding Network) and other organisations can provide invaluable help and support for the parent and carer. Other organisations such as Home Start (http://www.home-start.org.uk/) could be involved in order to help a family struggling to cope with the children and who are finding parenting a challenge. There are other organisations offering positive parenting programmes. It could be seen as negligible to wait until the next time the child presented with the same symptoms before stepping in and actually offering the family some support. The next time the injury could be twice as bad or even fatal. Suggested wording could be:- Take one or more of the following courses of action, record the action(s) taken and the outcome: • discuss the case with a senior colleague and/or a named or	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						designated professional for safeguarding children • gather collateral information from other disciplines within health and other agencies • review the child at a later date, looking out for repeated presentations of this or any other indicator. • Find out what the voluntary sector has to offer and encourage the parent / carer to seek their help, information and support.	
SH	Breastfeeding Network	3	NICE	1.2.4	9	We would suggest detailing specific types of cultural practice which health professionals need to know are harmful to children since otherwise this would be open to interpretation.	Thank you for this suggestion. The GDG's view is that mentioning specific (and obvious) harmful practices has the potential to detract from the general message.
SH	Breastfeeding Network	4	NICE	1.2.7 / 1.2.8	9	Good to see included.	Thank you.
SH	Breastfeeding Network	5	NICE	1.3.1 Physical features – general Also ties in with section 1.4.10	10 18	We feel the guidance should be very specific on the types of presenting injury and we feel strongly that a note on acting appropriately about the situation is absolutely crucial – particularly with those health professionals who may have no experience of working with children prior to their current work. We note that in some paragraphs it says:- "when the explanation is implausible, inadequate, inconsistent or discrepant with the pattern of injury or the developmental stage of the child" Perhaps it would be worth highlighting for this paragraph also?	Thank you. We feel that we have covered this within the definition of suspect where it is suggested that the healthcare professional follows statutory child protection procedures. The first recommendation in this section identifies features of a bruise which on their own should alert a healthcare professional to suspected physical abuse. We agree. We hope that the recommendations are written in such a way that they identify

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Whilst we are not condoning bad parenting in any way we are aware as parents that it can be impossible to supervise children all of the time (for example when going to the toilet or cooking a meal etc) indeed this would actually be unhealthy development for the child (having it's parent or carer in the room every minute of every day). We are wary that some of these injuries in the guidance could be caused during play with siblings or friends in the home. Jealousy / relationships between siblings and friends should also be highlighted. In our experience we are all too aware of how easy it is for a child to pick up an "implement" and hit another child with it (accidentally or deliberately). Having been children ourselves we will all have experienced this in one form or another. This can happen with very young children who may not yet be able to speak and give an explanation of what happened. The carer may not have even seen what happened. The work load would be phenomenal if child maltreatment were suspected for every bruise and cut a child presents with. We note that "unintentional injury" is being covered in another NICE guidance and perhaps it will be worth trying to tie these two important documents up at a later stage.	certain situations where the healthcare professional should consider maltreatment in the context of other differential diagnoses and when the explanation or surrounding circumstances are reasonable sensible decisions such as those that you point out will be made. We are grateful for this thoughtful comment. However, it is the aim of this document not to have every child with a cut or bruise referred to social services but to redress the balance where there is nearly always an assumption that every cut and bruise is innocent and thereby nothing needs to be done. Many reviews on children's deaths point to a failure to appreciate the significance of minor injuries which should have raised some concern and action being overlooked by health care professionals e.g. baby P. This is indeed the case. The injury prevention guidance is due to be published in 2010. We will pass this message on to the commissioning team at NICE.
SH	Breastfeeding Network	6	NICE	1.3.5	11	With regards injuries on the wrist perhaps it would be useful to note that marks made by being held on one wrist only (such as those	Thank you but we hope that this is covered in our recommendations in that this type of explanation might constitute a

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						made by an adult hand grabbing a wrist) may be considered a "plausible" explanation – as I'm sure many of us who have experienced an active 2 year old about to run out in front of a car or pull something over on themselves would agree. If the concern is where it appears to be on both wrists and possibly caused by a ligature this should be made clear.	reasonable/suitable explanation as long as consistent with injuries seen and thus not be considered suspicious of child abuse. The evidence would not support the fact that a ligature injury to one wrist would be less significant than if it affected both wrists.
SH	Breastfeeding Network	8	NICE	1.4.4	18	We strongly suggest the following paragraph be re-phrased "Healthcare professionals should consider neglect if a child displays faltering growth (failure to thrive) due to lack of provision of an adequate or appropriate diet." To:- " Healthcare professionals should consider neglect if a child displays faltering growth (failure to thrive) due to lack of provision of an adequate or appropriate diet and where medical causes have been ruled out by experts in the field of child growth" It would be negligent to suspect a parent of neglect where there could be a medical explanation. Where a breastfed baby presents and is failing to thrive a referral to a breastfeeding specialist	Thank you for your comment. The implication of the 'consider' statement is that reasons other than maltreatment are sought. We have amended the recommendation to read: Consider child maltreatment in any child with abnormal growth patterns, including failure to thrive, for which there is no medical explanation. We hope this addresses your concern about breastfeeding difficulties.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						as soon as possible is absolutely crucial, even during the phase of eliminating a medical cause which could take several days /weeks (This ties in with our additional bullet point in the action to be taken - order number 2). The mother will need intensive support to either increase her milk supply and or improve milk transfer to the baby or she will need help in dealing with milk in her breasts, to prevent mastitis, while the baby is supplemented.	
SH	Breastfeeding Network	11	NICE	1.5.3	20	Though not mentioned specifically we are aware of the condition Munchausen by proxy and the paragraph seems to take the assumption that a medical cause has already been ruled out. It may be worth highlighting in the paragraph that medical causes should be ruled out first and a second opinion sought if the same health professional has been seen each time the baby or child has presented. Health Professionals can not possibly be expected to know everything and we feel it would be worth a second opinion from a colleague or expert in the field before maltreatment is suspected.	Thank you for your comment. The GDG believes that repeated ALTEs can be dangerous and, as such, should warrant urgent action. This is why the GDG has chosen 'suspect' for this presentation.
SH	Breastfeeding Network	12	NICE	1.5.10	22	This does not appear to take in to consideration those children who are adequately home educated. We would suggest rewording the title to:- Inappropriate or unexplained poor school attendance in a child not known by the Local Education Authority to be being adequately home educated.	Thank you for pointing this out. The recommendation now reads "consider child maltreatment if a child has poor school attendance that the parents or carers know about that has no justification on health, including mental health, grounds *and formally approved home education is not being provided*." We hope this change is helpful.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Breastfeeding Network	13	NICE	1.6.3	23	Suggest menstruation / premenstrual symptoms / testosterone surges be mentioned specifically as an explained cause for changes in behaviour.	Thank you for your comment. Such causes for change in behaviour would be expected for a child's developmental stage and, as such, are already covered by the recommendation.
SH	Breastfeeding Network	14	NICE	1.6.6	24	We suggest 'habits' be discussed since some of these behaviours (particularly picking) could be more associated with being a habit and not because the child is being maltreated.	Thank you for your comment. Recommendation 1.4.2 refers to the habit of rocking, which was the one the GDG considered relevant.
SH	Breastfeeding Network	15	NICE	1.6.8	24	The guidance does not explain how this would present to the health professional. If the parent reports concerns that the child is displaying any of these behaviours it could be worth examining whether these are a normal part of growing up. In isolation some of these should not be interpreted to indicate maltreatment. I would imagine most of us who have had a normal healthy childhood may have scavenged food at some time or another or hidden food away with the intention of having a "midnight feast".	Thank you for your comment. The GDG notes this comment and will amend the recommendation to include the word 'repeatedly'.
SH	Breastfeeding Network	17	NICE	1.6.15	25	It could also be worth noting any influences, such as the part the television / media / internet play in making children behave in a certain way. Some music videos are quite explicit. Children copy what they see.	Thank you for your comment. These are risk factors which fall outside the scope of the guidance.
SH	Breastfeeding Network	18	Both	1.7	26	Within the guidance we would like to see some additional aspects around infant / child mental health included. The UNICEF publication ***The child care transition A league table of early childhood education and care in economically advanced countries***. **(**Innocenti Research Centre, Report Card 8) highlights concerns	Thank you for this information. The topics you refer to are outside the scope of the guidance; the guidance is not a guide to parenting. However, when this amounts to emotional unavailability and emotional unresponsiveness to the child, this is covered under emotional neglect.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						around the child not being raised by the parents, in particular the mother, who often has to return to work early and leave the child. To use an abstract the publication highlights how childhood is changing and how: "*Today's rising generation is the first in which a majority are spending a large part of early childhood in some form of out-of-home child care.* *At the same time, neuroscientific research is demonstrating that loving, stable, secure, and stimulating relationships with caregivers in the earliest months and years of life are critical for every aspect of a child's development.* *Taken together, these two developments confront public and policymakers in OECD countries with urgent questions.* *Whether the child care transition will represent an advance or a setback – for today's children and tomorrow's world – will depend on the response."* This document can be found at http://www.childwellbeing.org.uk/documents/Report-card-8.pdf We are aware that many of the modern parenting books and some health professionals encourage early separation from the baby from a very young age, with a particular focus on the mother's relationship with the father rather than on the relationship with her baby and the family as a whole unit.	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						This idea does not take in to account the needs and emotional distress of the baby. In addition is often goes against what the individual mother would want to do herself, which our anecdotal experience of taking calls on a breastfeeding helpline, supports. Sue Gerhardt in her book *Why Love Matters: How affection shapes a baby's brain* (Brunner-Routledge, Scarborough (Canada) and New York, 2004) highlights: *"The baby's mother is primed to do these things for her* *baby by her own hormones, and is more likely to have* *the intense identification with the baby's feelings that it* *is needed, provided she has the inner resources to do* *so."* Another area we would like to see included is that of "controlled crying". The Australian Association for Infant Mental Health Inc. (Affiliated with the World Association for Infant Mental Health, www.aaimhi.org, Position Paper 1: Controlled Crying, Issued November 2002; Revised March 2004) which can be found at http://www.aaimhi.org/documents/position%20papers/controlled_crying.pdf The paper suggests that controlled crying is:	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						"not consistent with what infants need for their optimal emotional and psychological health, and may have unintended negative consequences"	
SH	Breastfeeding Network	19	NICE	4.4	30	We agree more research is needed to discriminate between maltreated and non-maltreated children	Thank you.
SH	British Association for Adoption and Fostering	1	NICE	general	General	We found the guidelines to be generally clear and helpful	Thank you.
SH	British Association for Adoption and Fostering	2	NICE	1.6 and 1.7	22-27	It is important that health professionals are aware that some looked after and adopted children who have a history of early trauma, loss and / or neglect may have disturbances of attachment, or emotional and behavioural difficulties which may need to be distinguished from child maltreatment by the current carers. The context must be considered to prevent casting suspicion on substitute carers who are parenting children who have 'brought pathology into the home'.	Thank you for this comment. The GDG has added the following words at line 24: (…bipolar disorder) and the effects of known past maltreatment have been explored.
SH	British Association for Adoption and Fostering	3	NICE	1.1 and 1.2	7 -9	It is extremely important that the health workforce appreciate the urgency and know who to contact if child maltreatment is suspected. The role and workings of ContactPoint could usefully be considered in the guidelines.	Thank you for this suggestion. Prior to consultation, the GDG had considered ContactPoint as a resource for inclusion. As this facility has not been rolled out yet, the GDG is unable to recommend it as a reference point. We will, however, pass your suggestion on to the implementation team at NICE who will hopefully take it forward at a later date.
SH	British	4	NICE	1.2.8	9	Acknowledgment of the stressful nature of this	Thank you for your comment. Unfortunately,

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Association for Adoption and Fostering					work should be more robust, with a focus on development of appropriate resources to support health care professionals. This should include relevant training for all staff, as uncertainty concerning evidence and decision making may accentuate stess levels.	training for staff is outside the scope of this guidance.
SH	British Association for Adoption and Fostering	5	NICE	general	General	The need for appropriate training in this area should be emphasised , and should include process maps of the appropriate local roles and posts which might be utilised.	Thank you for your comment. Education and training for healthcare professionals are outside the scope of this guidance but we will pass your comment on to the implementation team at NICE.
SH	British Association for Community Child Health	1	NICE	general	general	This guideline will be helpful in raising awareness of the wide range of signs and symptoms which should give rise to concern about possible maltreatment. It would be important to make clear its applicability to all those who deal with children and young people, not just to those in specialist children's services. Training is needed for this wider group and making it a mandatory part of their professional development may be necessary for some groups, if it is not already	Thank you for commenting on this draft guidance. The GDG agrees with your comment about training and will pass it on to the implementation team at NICE who are responsible for producing tools for the implementation of the guidance, including training tools.
SH	British Association for Community Child Health	2	NICE	general	general	The support of the wider public, media etc for child protection work could be improved through awareness raised by this document	Thank you. We hope this will be the case.
SH	British Association for Community Child Health	3	NICE	1.2.3	9	Where the guideline advises of the need to call appropriately on other disciplines and agencies in the process of substantiating/not substantiating maltreatment, those disciplines and agencies need to have the capacity to meet such expectations and to include such	Thank you for this helpful comment. Resources in other agencies are outside the scope.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						work in their referral criteria	
SH	British Association for Sexual Health and HIV (BASHH)	1	Full	General		General point: Use term children and young people in text where relevant rather than using only child/children	Thank you for this suggestion. This change has been made where appropriate.
SH	British Association for Sexual Health and HIV (BASHH)	2	Full	Glossary of terms	12-13	Ensure consistency of terms and definitions between RCPaedCH publications	Thank you. We agree that consistency here is of utmost importance. This was our intention but we would agree that we have abbreviated the definition of hymeneal laceration and have therefore amended to "A fresh wound made by tearing through the hymen which may be partial or complete."
SH	British Association for Sexual Health and HIV (BASHH)	3	Full	2.1	23-24	BASHH are responding only to sections related to Sexually transmitted infections and pregnancy. BASHH agrees that sexual abuse should be suspected *or considered* in a child below 13 years of age with a sexually transmitted infection. Although these infections can be transmitted vertically (mother to child transmission, peri-natally), or some via infected blood products) they can be transmitted sexually in adults and there is varying strength of evidence for the separate infections as indicators of child sexual abuse. The evidence is stronger for some infections rather than others, and household transmission can occur for eg Hepatitis B. The issue is therefore whether all STIs named should be under "suspected" or whether some should be under "considered". It may be that for this section wording is changed to "	Thank you for this helpful comment. We have addressed your points and separated the list of STIs so that hepatitis B and anogenital warts have their own sets of recommendations that account for household transmission.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						suspected/considered according to the type of STI and that advice should always be sought from an expert, taking into consideration the RCPCH guidelines and any more recent research evidence". For 13-15 year olds we agree with the statement, but it should also add "or when there is clear evidence of vertical transmission for HIV/Hepatitis B/Hepaptitis C , bearing in mind that infection in a parent does not necessarily exclude sexual transmission through child sexual abuse". This should also be added to the section on 16-17 years olds.	
SH	British Association for Sexual Health and HIV (BASHH)	4	Full	2.1	24	Regarding non-consensual activity with 16-17 year olds. In line with those over 18 years, those 16-17 who have been the victim of an acute sexual assault (where this is not related to incest/someone in position of power) may choose not to report to the police, but still wish to attend sexual health services for an STI screen, pregnancy prevention and prophylaxis against HIV and Hepaptitis B. It must be clear in the guidance that these young people will retain the right to access care, without having to be referred on to police or child protection services, unless there is an issue of incest/assault by someone in position of power.	Thank you for your comment. The GDG notes, this comment and for this reason has advised 'considering' maltreatment. There is no obligation to refer young people in this circumstance.
SH	British Association for Sexual Health and HIV	5	Full	General		We suggest inclusion of this statement " If a decision is made to break confidentiality of a young person, the consent of the young person should be obtained. If consent is refused this should be discussed within the	Thank you for this suggestion. This has been addressed in the actions associated with considering maltreatment and reads: "gather collateral information from other disciplines within health and other agencies, having used

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	(BASHH)					team and/or other childcare professionals and any decision for breaking or not breaking confidentiality should be recorded, in line with guidance including "Working Together to Safeguard Children", GMC guidance for doctors etc. "	professional judgement about whether to explain to the child, young person and/or parent/carer your need to gather this information because of the need for an overall assessment of the child".
SH	British Association for the Study and Prevention of Child Abuse & Neglect (Northern Ireland Branch)	1	Both		General	These documents are very useful and constructive additions to the guidance on child abuse and neglect provided to health professionals working with children and families. It would be the view of the Northern Ireland Branch of BASPCAN that the guidance be extended to Northern Ireland in line with the remit of NICE. This would not require any substantive changes to the content or structure of the guidance, although it would be useful to include a footnote that indicated that the legislative, structural and procedural framework is different in Northern Ireland.	Thank you for raising this. According to guidance from DHSSPS, the decision on whether to disseminate NICE guidance rests with them. The GDG cannot therefore make specific reference to statutory documents relating to Northern Ireland. The process by which DHSSPS makes its decision would enable an effective translation of this document to suit local legislation.
SH	British Association of Art Therapists	1	Both	General		We welcome the timely publication of these Guidelines. The following, bulleted points are made with reference to the sections of the document quoted below, and also as general information.	Thank you for commenting on this draft.
SH	British	2	Full	2	P29/8	What aspects of emotional and behavioural	Thank you for these comments. Members of

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Association of Art Therapists				1	states discriminate maltreated from non maltreated children? Emotional, behavioural, and interpersonal/ social functioning. Whilst we are aware of the distinction between assessment and treatment, there remains an unexplored domain within your evidence selection, in terms of the presence of and creation of disturbing art work. Such non verbal signs of potential maltreatment need to be broached with caution. Since, historically a heavy emphasis is placed on verbal disclosure, as you point out changes in behavioural and emotional states may suggest maltreatment. However securing evidence of distress is problematic, the use of play and art in the context of a therapeutic relationship may also illicit telling information about the presence of an abusive relationship within a Childs life. Caution however is important in the interpretation of images drawn or painted by a child or subsequently used as evidence in a court of law. (Douglas, 2001) • It is very important in itself that there is some clear guidance that drawings cannot be interpreted by any general standard. See Learmonth, Malcolm, Articulating Art	the GDG recognised your concerns, but as this guideline is intended for front-line healthcare professionals who will not generally know the child 'in the context of a therapeutic relationship' and as such it was not felt appropriate to offer advice about issues that might arise in the course of more prolonged, specialist involvement with a child.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Therapy A training resource for Art Psychotherapists. (2005) Insider Art: UK. • Arts therapists can comment from the context of art/ play products linked with processes and in the context of a therapeutic relationship. Not all disciplines have sufficient training and competence to do this in such an advanced manner. • It is important to have people with specific training in symbolic communication on a team for safeguarding reasons, so that important information is not missed. Child observation studies demonstrate that children and young people naturally express themselves through play and creativity. It is vital to speak the same language as the child and conduct interviews in a child centred way. Art therapists are good at engaging hard to engage children and families with challenging presentations, and this is vital in practitioners being able to conduct a full assessment. Establishing a relationship with a client is a significant step towards identifying child maltreatment. The document 'Targeted	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Mental Health in Schools Project' (DCSF, Nov 2008) is very clear that practitioners should be in possession of a range of creative skills so as to gain the participation of service users, and that in this respect, practice based evidence (ie. qualitative information about what young people engage with) is of great importance. Timely research is required in to the non verbal, art based disclosures of maltreatment Douglas L (2001) "Nobody Hears" How assessment using art as well as play therapy can help children disclose past and present sexual abuse. Art Therapy with Young Survivors of Sexual Abuse, Lost for words. Ed J Murph. pp 51-66 Brunner/Routledge	
SH	British Association of Play Therapists	1	Full	1.2	14	BAPT note the timely guidelines that may encourage recognition of the possibility of child abuse in children. Since 1975 and the Maria Coldwell tragedy many child deaths have shown the presence of physical signs of child abuse and neglect.	Thank you for commenting on this draft guidance.
SH	British Association of Play Therapists	2	Full	1.3	15	We note the limitations of the guidelines in relation to action re suspicions. This has significant implications for training and clear reporting procedures. An obstacle to recognition exists where the professional is ill-informed about what action to take, what action not to take and how they as individual professionals can feel supported in fulfilling the role of alerting others to possible early	Thank you for your comment. We will pass it on to the implementation team at NICE who will be working with other agencies who are developing training tools for this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						indicators of child abuse. Effective protection of the child is only likely to take place if the guidelines are contextualised and individual health professionals are empowered to take appropriate action on suspicions.	
SH	British Association of Play Therapists	3	Full	2.1 10	20	Reference is made to accessing local child protection procedures. BAPT is concerned that there is progressive isolation between health, education and social services in relation to effective working together. It is important that frontline professionals feel that reported concerns are taken seriously and procedures followed if they are to be encouraged to report potential abuse and neglect.	Thank you. The GDG agrees with your sentiment and will pass your comment to the implementation team at NICE.
SH	British Association of Play Therapists	4	Full	2.1 8/9	20	Recording for the purposes of child protection needs to be done to evidential standards. This has implications for training and awareness of the child protection process.	Thank you for your comment. The recording of information has been clarified to 'record in the child or young person's clinical record exactly what is observed and heard from whom and when '
SH	British Association of Play Therapists	5	Full	2.1 26/35	20	The guidelines do give useful contextual information and research findings, but confidence in making an initial assessment of contextual factors that direct the professional to consider child maltreatment can be affected by lack of training. Contextual factors frequently involve a subjective assessment of qualitative evidence. Another issue of effectiveness may be the time available to reflect on a child's situation and the quality of supervision of the professional.	Thank you for this comment. Contextual factors (risk factors) for maltreatment are outside the scope of the guidance and so it is difficult us to comment on this aspect within the guidance.
SH	British Association of Play	6	Full	2.1 36	20	BAPT welcomes the emphasis placed on disclosures by a child. However, most abused children would not make direct disclosures	Thank you for your comment. Empowering children to disclose is beyond the scope of the guidance. This guidance focuses on health

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Therapists					because of fear of consequences. Some children will indirectly offer information and make more direct disclosures if a safe adult is sensitive to this. Empowering a child, especially a young child, to make disclosures and feel safe in doing so is a skilled task requiring training and confidence on one's professional judgement. This again has implications for the training and support of frontline health professionals to act as early warning systems for the protection of children.	professionals' observations that raise initial suspicion. Communication with children in relation to suspicions is outside the scope of the guidance.
SH	British Association of Play Therapists	7	Full	2.1 40	27	BAPT recognises that detecting child sexual abuse is a complex and delicate challenge to health professionals who might very well play the most significant role in alerting other professionals. The guidelines highlight symptoms that are the most obvious, but consideration of child sexual abuse should not be excluded if these symptoms are not present.	Thank you for this comment. The GDG agrees with your view but is restricted by the scope to raising awareness of maltreatment when symptoms/signs are observed.
SH	British Association of Play Therapists	8	Full	2.1 15	28	Assessing whether there are child protection concerns based on the observed quality of parent-child relationships is an essential role carried out by primary care professionals. The guidelines draw attention to qualitative factors which have a subjective element. Training and awareness is essential if such health professionals are going to feel confident and supported in making such assessments.	Thank you for your comments. Training for healthcare professionals is outside the scope of this guidance but we will pass your concerns on to the implementation team at NICE.
SH	British Association of Play Therapists	9	Full	General		BAPT welcomes the guidelines that emphasise the role of health professionals in detecting child maltreatment and facilitating early intervention. We believe there are significant implications for training, work levels,	Thank you for your comment. Education and training for healthcare professionals is outside the scope of this guidance but we will pass your concerns on to the implementation team at NICE.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						supervision and support to those professionals. We believe that there should be greater multi-disciplinary training on the issue of child protection. We would hope that these guidelines are integrated into all qualifying training for health practitioners. BAPT would also draw the attention of NICE to the importance of considering the role of independent health professionals e.g. therapists, who practice outside of the mainstream health service provision. Such guidelines are equally relevant, but careful consideration on reaching these health professionals needs to be given as the mainstream dissemination approach may leave them isolated.	Thank you for this suggestion. "and in the independent health sector" has been added.
SH	British Nuclear Medicine Society	1	Nice	4.1 Fractures	29 of 38	My comments are as follows; The second paragraph in the section 4.1, "why this is important" is difficult to understand, being one long sentence. Re-wording of this paragraph is advised. Consider splitting up paragraph. A prospective comparative study of fractures resulting from physical abuse, conditions leading to bone fragility and those resulting from accidental trauma is needed. This study should specifically look at metaphyseal fractures as the existing evidence base does not fully account for differential diagnosis of fractures in the infant and toddler age group.	Thank you, for your suggestion. Changes have been made to this paragraph to ensure clarity.
SH	British Psychological Society, The	1	Full	5	general	Many of the indicators of neglect, such as impaired cognitive development, failure to thrive, over- and under- nutrition and reluctance of a parent to immunise a child, are	Thank you. This point is acknowledged but the GDG has attempted to exclude those parents who actively participate in caring for their children by engaging with professionals. If

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						also associated with autism spectrum disorders. A child's sensory hypersensitivities can lead to problems with footwear, personal hygiene, diet and dental care. Neurodevelopmental disorders are not mentioned in the chapter on neglect. We should like to see this point included in chapter 5.	there is evidence of this, such parents are not neglectful. This applies to the vast majority of parents and carers of children with autistic spectrum disorders.
SH	British Psychological Society, The	2	Full	7	P26 and P28	Many of the indicators of emotional, behavioural and interpersonal/social functioning are also indicators of developmental disorders. This issue is noted in the guidance (pp.26 & 86), and practitioners are expected to explore this possible cause prior to suspecting maltreatment. However, given the difficulty in diagnosing disorders such as autism and ADHD, the time taken to diagnose, the relatively small number of practitioners experienced in this area, and divergence of opinion over causal models for these conditions, we are concerned that child maltreatment may be wrongly suspected in these cases. It is important that the origins of the indicators of possible maltreatment are correctly identified.	Thank you. These recommendations have been written in this way to highlight the need for heath professionals to exclude these neurodevelopmental disorders.
SH	British Psychological Society, The	3	Full	General	General	Overall we thought the guideline was very comprehensive, providing useful guidance and evidence.	Thank you.
SH	British Psychological Society,	4	Full	7.2	P94 and P98	Parents and carers are significantly more likely than any other group of adults to abuse children. This is not surprising given the	Thank you for your comment. Provided parents take action to protect the child from further bullying in school, bullying itself is not included

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	The					amount of time children spend in the home. However, most children also spend a significant amount of time at school. The physical maltreatment of children by school staff in school has essentially been eradicated, but this does not mean that neglect and emotional abuse have suffered the same fate. Bullying at school (presumably by other children) is mentioned in the guidance (pp. 94 & 98), but the possibility that a child may be showing signs of neglect or emotional abuse because of other experiences in school is not acknowledged. The indicators of neglect or emotional abuse arising from experiences at school might not be the result of deliberate maltreatment by teachers. A school's failure to provide appropriate educational support, or the failure to prevent bullying by other children (both well-documented phenomena) could produce the indicators of maltreatment listed in the guidance. The possibility of neglect and/or emotional abuse in the child's school situation should be investigated as a matter of course, especially if school attendance is poor. The omission from the guidance of school as a source of child maltreatment is a serious oversight.	in this guidance.
SH	British Psychological Society, The	5	Full	General	General	Regarding behavioural signs each is taken separately and sometimes it is the presentation of a cluster of signs which may cause alarm. A young person taking drugs and alcohol may in itself not be a sign of maltreatment, but when that young person is	Thank you for your comment. The GDG has accounted for clusters of signs by allowing a single sign to lead a professional to consider maltreatment and in so doing may observe other indicators.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						also self harming, absconding and getting so drunk or high they cannot remember anything then this would be a cause for alarm. The document needs a section which talks about clusters of behavioural/psychological signs. Also dissociation is often seen in association with other trauma symptoms.	
SH	British Psychological Society, The	6	Full	6.4	74	In the section which refers to fabricated illness, it may be useful to put in a section about types of services this may be more likely to present at, so symptoms like gastric problems, vomiting, non-organic failure to thrive may be highly likely to all present at feeding clinics. People in these settings may need to be particularly aware.	Thank you for your comment. The GDG's view is that this information is too specific for the purposes of the guideline.
SH	British Psychological Society, The	7	Full	7.1	Page 82	The section on challenging and antisocial behaviour gives several reasons why a child may be antisocial due to witnessing violence and failure of parents to set boundaries. Other reasons may be actual abuse and emotional distress, emotional dysregulation, which the child is unable to cope with.	Thank you for highlighting this. In this section, the GDG wished to address how these behaviours may be caused by maltreatment.
SH	British Society of Paediatric Dentistry	1	NICE	general	general	The document is readable and easy to follow.	Thank you.
SH	British Society of Paediatric Dentistry	2	NICE	1.1	7 - 8	We welcome the clear definition of 'suspect' and 'consider', linked closely to what is expected that the health professional would do. It would be helpful if (a) the formatting emphasised the importance of this paragraph to understanding the whole document and (b)	Thank you for this suggestion. We have been working with the editorial team at NICE who have advised us on such matters of presentation.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						for these two key words to be highlighted throughout the document (e.g. in bold or a different colour).	
SH	British Society of Paediatric Dentistry	3	NICE	1.2.4	9	This statement is confusing. It needs to state whether or not it is acceptable for cultural practices to be harmful for children.	Thank you. This section has been amended to ensure clarity.
SH	British Society of Paediatric Dentistry	4	NICE	1.3.6	11	Bullet point 6, if read without the accompanying introductory sentence, misleadingly implies that you should suspect abuse if any injury occurs at any of these sites. The mouth is commonly injured accidentally in falls e.g. toddlers against coffee tables, older children from bicycles. 'Mouth' should be omitted from this list since it is covered by a much clearer statement in point 1.3.17, page 14.	Thank you for this comment. We hope that it is extremely unlikely that the individual items on the bulleted list would be read without the introductory text, particularly as they all start with a lower case letter and this indicates that they are not statements in their own right. Mouth has been removed from this list.
SH	British Society of Paediatric Dentistry	7	NICE	1.4.5	18	Could failure to attend to oral health be added here, or is it considered to be embedded in the term preventive child health promotion programmes?	Thank you. Oral health is covered in a separate recommendation.
SH	British Society of Paediatric Dentistry	8	NICE	1.5.1	19	Children with repeated dental injuries may present in different services, with the consequence that no healthcare professional is aware of previous injuries. Could dental injuries possibly be reported to a central location such as the local PCT?	Thank you for this interesting point. This refers to service organisation, which is outside the scope of this guidance.
SH	British Society of Paediatric Dentistry	9	NICE	5.2	31	A well-written succinct quick reference guide is essential for implementation of this guidance by busy practitioners.	Thank you for your comment. We have been working with the editorial team at NICE to ensure a high quality product.
SH	British Society of Paediatric	10	Full	2.4	31	The flowchart is excellent, especially in repeating the definitions of 'suspect' and 'consider'. Please consider giving it much	Thank you. We will give this due consideration and will raise it with the editorial team at NICE.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Dentistry					greater prominence and including it in the NICE version and the quick reference guide.	
SH	British Society of Paediatric Dentistry	11	Full	GDG	5	There are inconsistencies in the amount of detail included regarding job titles and place of work of the external reviewers.	Thank you for your comment. Details of UK-based external reviewers have been amended and are in-line with the presentation of those of the Guideline Development Group members. The USA-based reviewers are now presented under a separate section and there the details relating to place of work have been retained as it was felt that they would be less easy to identify for the UK readership.
SH	British Society of Paediatric Dentistry	12	Full	Appendix A	108	There are inconsistencies in the amount of detail and type of information included regarding GDG members' interests. Some information appears to be unnecessary compared to the requirements stated on page 16.	Thank you. We have made modifications to the presentation of this information where required. However, the extensive nature of the interests declared is also attributable to the NCC-WCH's implementation of the NICE policy which requests both personal pecuniary and non-pecuniary as well as non-personal pecuniary and non-pecuniary interests to be declared. Advice received from NICE has been to err towards over-declaring interests to avoid any material conflicts of interest being undeclared.
SH	British Society of Paediatric Dentistry	13	NICE	general	general	This document is clear, helpful and relevant to our members. The full guideline and NICE guideline are likely to be well used by the small number of our members who have a special interest in this field. However, it is only likely to have a positive impact on practice in general if (a) a well written quick reference guide is disseminated widely and (b) if support is given to practitioners to implement the guidance. In particular, practitioners need advice on how to raise the subject when they suspect	Thank you for your comments. Education and training for healthcare professionals is outside the scope of this guidance but we will pass your concerns on to the implementation team at NICE.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						maltreatment, e.g. advice on suggested phrases to use, perhaps a leaflet to give to parents and children. Our members have been unable to find any such resources to help them prepare for this aspect of the referral process and it is not always covered in training for health professionals. We recognise that 'communication of suspicions to parents and/or the child' is stated to be outside the scope of the guideline but this is an area that needs urgent attention.	
SH	BSPGHAN	1	Full	general		We feel that it is important to highlight that there are two NSF's –England and Wales and as NICE guidelines apply in Wales, this should be acknowledged in the introduction instead of "The NSF" etc	Thank you. This change has been made.
SH	BSPGHAN	2	Full	general		Summary is too long and needs significant editing to be useful as a summary	Thank you for your comment. This summary is the complete list of recommendations that appear in chapters 3 onwards. The same list appears in the NICE version. We have been working with the editorial team at NICE to produce a Quick Reference Guide. The recommendations will be presented in a practical summary.
SH	BSPGHAN	3	Full	general		The guideline has limited use (for paediatricians)as it does not really indicate what to do beyond the suspicion	This issue is outside the scope of the guidance.
SH	Cafcass	1	Full	1.1	14	The final paragraph at points 28 – 31 are crucially important and read – " In order for effective child protection to occur, all agencies must cooperate and do so at the earliest point possible. This guidance addresses the crucial contribution of healthcare professionals to this	Thank you for this suggestion. The GDG notes your comment but wishes to end this section on a strong note.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						endeavour, by setting out the indicators which will alert healthcare professionals to the recognition of possible child maltreatment". It is noted and suggested whether this statement should be noted in bold, or come higher up within the introduction.	
SH	Cafcass	2	Full	2	20	At points 42 and 43, but also at other points in this and the NICE guideline document, it refers to – "Healthcare professionals should be aware that some child maltreatment may be explained as, or mistaken for, cultural practice; a small number of cultural practices are harmful to children". This comment could be misleading and is not very clear. A comment would be to give examples of this to help guide professionals appropriately.	Thank you. This section has been amended to ensure clarity.
SH	Cafcass	3	Full	General (several references)	31, 38	Within this document and the NICE guideline there is reference to when to "suspect" child maltreatment and when to "consider" child maltreatment. An explanation of this is given in the NICE guideline at section 1.1. There is also a flow chart at page 31 (main document) and 38 (NICE guideline) respectively. In respect of this flow chart, it is useful to have a "considered" category and procedure to follow, where further exploration will be undertaken. Cafcass would suggest including a dotted line from all of the 3 boxes at the bottom (i.e. Discuss the case with a senior colleague…Gather collateral	Thank you for theses suggestions. The flowchart has been revised in the light of changes made to the definitions of 'consider' and 'suspect'. We hope these changes are helpful and that the depiction in the flowchart is clear.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						information…Review the child at a later date… etc) into the main box on the suspect side of the flow chart i.e. into "Follow local guidance on what to do when you think a child is being abused or neglected". Cafcass also suggests making a link from the "considered" side into the "suspected" side as a reminder of the main procedure to be followed where concerns arise, and may continue.	
SH	Cafcass	4	Full	General (several references)	8, 31, 38	In respect of the flow chart, the main document on page 34 (points 11 – 15), and at page 8 of the NICE guideline in section 1.1.2 "Take one or more of the following courses of action, record the action(s) taken and the outcome: • discuss the case with a senior colleague and/or a named or designated professional for safeguarding children • gather collateral information from other disciplines within health and other agencies • review the child at a later date, looking out for repeated presentations of this or any other indicator" Cafcass would suggest that rather than one or more of these courses be followed that it is recommended that all 3 are followed, and that this is also noted on the flow chart.	Thank you for this suggestion. The GDG's opinion is that there must be flexibility when 'considering' maltreatment because of the potential for an alternative explanation to be found.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Cafcass	5	Full	General (several references)	See above	Continuing with this flow chart and the associated points in the main documents, it may be worth adding that the "review" of the child "at a later date" be kept to a tight timescale to ensure appropriate monitoring takes place, and, therefore, IF it becomes "suspected" maltreatment there has been no unnecessary delay in health professionals alerting Social Care (ie the Local Authority, previously known as Social Services).	Thank you for theses suggestions. The flowchart has been revised in the light of changes made to the definitions of 'consider' and 'suspect'. We hope these changes are helpful and that the depiction in the flowchart is clear.
SH	Cafcass	6	Full	6 - 10	36	Reference is made to "The GDG believes that the age of a bruise cannot be judged reliably from interpretation of the colour of a bruise and should not be used in the assessment of bruises". Cafcass would suggest that this should this be an area of further investigation however, to provide more factual information. Clearly the importance of the "timing" as to when a bruise has been caused is important, and especially for the police, in identifying suspected perpetrators of that bruise (i.e. potential assault) and in ruling out others. Therefore to provide more detailed information around the colouration and dating/timing of bruising may be a useful addition.	Thank you for this suggestion. We are aware that this is currently being investigated by the PROTECT project at Cardiff university (an MRC-funded research project).
SH	Cafcass	7	Full	4.1.2	37	It would be useful to note the importance of forensic evidence here, and in the measuring of the teeth to indicate a potential perpetrator.	Thank you for this suggestion. The following sentence has been added to the introduction: "Forensic evidence is usually required to identify the perpetrator."
SH	Cafcass	8	Full	41	8	Reference is made to "child known to social	Thank you. This has been amended to

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						service". If this could be corrected to "social care".	'children's social care'.
SH	Cafcass	9	Full	53	14-15	Reference is made to " all healthcare professionals who are concerned about maltreatment should inspect the child's mouth". This is good guidance and it is clear how this could be overlooked, and additional injuries in this area could be missed. Cafcass suggest this is and cross-reference into other professionals procedures as an important point (e.g. highlighted on training courses etc).	Thank you for your comment. The GDG agrees that this is important but, unfortunately, it is outside the scope of this guidance for us to make recommendations about what to do once maltreatment is suspected.
SH	Cafcass	10	Full	53	25-31	On the section "In the case of suspected sexual abuse, most general pediatricians will not have the expertise to assess or manage the child/young person themselves but will refer to a clinician with more specialised child protection expertise and with training in forensic assessments. Children presenting with concerns about physical abuse, neglect or emotional harm, also require an inspection of the genitalia and anus as part of the full examination". Ano-genital signs may be identified by healthcare professionals in their routine assessment of children for symptoms related to that anatomical area. Cafcass has several points to make: • We question should the genital area be examined IF there are no concerns of any harm to that area? We understand this was concern from Cleveland Report, and would ask the	Thank you for your comment. We have amended the introductory paragraph in this section. We hope that our changes imply that we are not recommending front-line health professionals to complete full examinations of the genital area.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						group to check this point carefully. • It is noted that a specialist should do this examination. Cafcass would point out is it not good practice for a medic who is also accepted by the police in their investigation be contacted, i.e. a police surgeon - firstly this could result in evidence being lost, or seen to be "tampered with" if they are not used from the outset; secondly that the child could have to have a further medical examination by the police surgeon for the purposes of the police action/s. • Cafcass would also like reference to the emotional affect on the child/young person that also must be considered at all times. It is worth noting that all must care in making enquiries and investigations, and be aware of the detrimental affect on the child/young person if this is not carried out appropriately. • In some Local Authorities the person appointed to do these examinations, having been agreed as suitable and as meeting all requirements. This is good practice and Cafcass would like this considered in the guidance.	
SH	Cafcass	11	Full	General (several references)	107	See also page 107 of the main document, and page 26 and 27 of the NICE guideline. This section refers to Healthcare professionals "should consider" emotional abuse, and list five	Thank you for this suggestion. The GDG has now revised the recommendations in this section to read: "consider emotional abuse when there is concern that parent-child interactions may be

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						examples. These five examples are quite concerning and if these were apparent Cafcass would suggest this is "suspected" and not "considered" maltreatment (and cross referenced in other sections of the guidance)	harmful…." "suspect emotional abuse when persistent harmful parent-child interactions are observed or reported…" A similar model has been adopted for the recommendations on emotional neglect. We hope these changes are helpful.
SH	Cafcass	12	Full	General		CAFCASS are not listed as a stakeholder organisation; could we be listed.	NICE has added your organisation to the list.
SH	Cafcass	13	Full	General		Overall this is a very up to date document. The studies quoted are very detailed and provide an excellent point of reference.	Thank you.
SH	Cafcass	14	Full	General		The overall document has based its criteria on that from Working Together to Safeguard Children (2006). This is universally used which is helpful.	Thank you.
SH	Cafcass	15	General	General		Cafcass acknowledges the combined expertise and experience of the Members of the GDG, and that the stakeholder organisations who have contributed to this guideline, are also well known and well respected in this field.	Thank you.
SH	Cafcass	16	Full	General	Particularly 29-30	Within the document are clear areas where further research is highlighted for further consideration in future, and this is also very helpful and appropriate.	Thank you.
SH	Cafcass	17	Full	General		The Glossary of terms is very succinct and	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						useful.	
SH	Cambridge University hospitals NHS Foundation Trust – Addenbrooke 's Hospital	1	Full	General		Thank you very much for giving me the opportunity to review the draft guideline 'When to suspect child maltreatment' as commissioned by NICE. Here are just a few comments and observations: The declared aim of the guideline is to set out indicators which will alert healthcare professionals to the possibility of child maltreatment but at the same time concedes that it does not constitute a definite assessment tool nor does it define diagnostic criteria. However, the latter is exactly what should be expected from a NICE guideline and such a statement probably reflects the fact that purpose, remit and outcome of the proposed guideline are ill conceived and of very little practical relevance and value.	Thank you for commenting on this draft guidance. The guidance has addressed the remit as provided by the Department of Health and NICE following a workshop at the scoping stage with key stakeholders.
SH	Cambridge University hospitals NHS Foundation Trust – Addenbrooke 's Hospital	2	Full	General		The list of 'areas outside the scope of the guideline' is long and unfortunate. In considering child maltreatment clinical signs can never be assessed without a robust surrounding framework which includes all items listed. An inclusive approach would obviously have been much more difficult and time consuming but reducing the remit of the guidance to the proposed defies its object.	Thank you for this comment. The GDG has addressed the remit as provided by the Department of Health and NICE following a workshop at the scoping stage with key stakeholders. However, the GDG notes the importance of these areas and suggests that you submit a theme for future NICE guidance. (**http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp**)
SH	Cambridge	3	Full	General		The key issue and probably main difficulty is	Thank you for your comment. It is the clinical

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	University hospitals NHS Foundation Trust – Addenbrooke 's Hospital					the definition of consideration versus suspicion as outlined on page 20. On the surface this seems a logical grading of the extent of concern, however, there is no clear guidance that would assist healthcare professionals to make the distinction between the two throughout.	indicator identified in the child that determines whether maltreatment should be considered or suspected; it is the GDG's aim that this is what leads the professional to make that distinction.
SH	Cambridge University hospitals NHS Foundation Trust – Addenbrooke 's Hospital	4	Full	General		It was particularly unhelpful that the guideline development group (CDG) would invariably recommend considering child maltreatment in clinical scenarios where there is overwhelmingly little evidence for causality in relation to child maltreatment, often following the Delphi consensus method. Where such a recommendation makes perfect sense is when it refers to very specific and age related injuries as those previously reviewed and published by the 'CORE' group in South Wales. However, there are a large number of other scenarios where this clearly does not work: Two examples are chronic abdominal pain and ALTE (apparent life threatening events). This is a theme that runs throughout the proposed guideline.	Thank you for this comment. The GDG's decision about whether maltreatment should be 'considered' or 'suspected' is based on available evidence and consensus from Delphi (in some cases) and ultimately the GDG itself. To 'consider maltreatment' means that maltreatment is a possible explanation. The 'consider' guidance has been altered and includes 3 options: the consideration leads: a) to suspect child maltreatment, b) to exclude child maltreatment, or c) to continue to consider child maltreatment.
SH	Cambridge University hospitals NHS Foundation Trust – Addenbrooke	5	Full	General		My other concern focuses on the expectation of how to address any consideration of child maltreatment as per flow chart on page 31. It was missing the scientific rigour that seems to have been applied to the rest of the guideline in reviewing the evidence (more often the lack thereof) when coming up with	Thank you for your comment. The flowchart represents the guideline development group's definitions of 'consider' and 'suspect' and their associated actions within the context of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	's Hospital					recommendations like 'discuss with the designated doctor' or 'review of the patient in order to seek out any persistence of indicators for child maltreatment'. By making such impractical (discuss every abdominal pain with the designated doctor?) suggestions the CDG goes beyond the remit it has set itself and it illustrates the difficulties in putting the recommendations into practice.	
SH	Cambridge University hospitals NHS Foundation Trust – Addenbrooke 's Hospital	6	Full	General		In summary, the proposed guidance tries to tackle the important issue of under recognition of child maltreatment. However, in its current form it is of very little practical value unless the issues of 'consideration vs suspicion' and the resulting consequences have been addressed and clarified.	Thank you for this comment. The GDG has clarified the actions around consider and suspect, but wishes to highlight that it is the clinical indicator that should lead the professional down one of these routes, not the other way around.
SH	Camden PCT	1	Full	1.1		Need 2008 figures.	Thank you for your comment. This has been updated.
SH	Camden PCT	2	Full	1.3		Distinguish guidance from proceedings and procedure following death as it would help the reader. The introduction should say this is guidance (+ definition) rather than procedures + definition).	Thank you for your comment. The GDG, however, does not fully understand your concern. The matter of child deaths was excluded from the scope because the systems in place in this country for dealing with child deaths are different to those for dealing with child protection. The scope focuses on child protection.
SH	Camden PCT	3	Full	1.7	table 1.1	by formal consensus do you mean Delphi, if so add in brackets	Thank you for your comment. This table is taken from the NICE guidelines manual, so it has not been altered. Formal consensus methods include Delphi as well as nominal group technique and others.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Camden PCT	4	Full	2.1	2.2	Eye trauma: include bilateral black eyes as blow to forehead which may be inflicted unless history issuggesting basal fracture or other trauma	Thank you. The evidence does not identify this feature as specific for maltreatment. This presentation may be seen in accidental injury. If, however, a child were to present in this manner where the explanation was unsuitable we feel that this would be covered by the recommendation regarding bruising.
SH	Camden PCT	5	Full	2.1	2.3	Oral injury. Also dental caries and neglect	Thank you for your comment. Please refer to the chapter on neglect where this is covered.
SH	Camden PCT	6	Full	2.1	21-28	Why is "health care professionals" repeated throughout? Who else and anyway, if a nursery worker noted only one of the signs he/she should be concerned.	Thank you for your comment. This document is primarily for use in the NHS. However, 'healthcare professionals' is no longer repeated throughout the recommendations as NICE has recently adopted an editorial style in which all recommendations are directive and therefore all recommendations have been changed to start with a verb.
SH	Camden PCT	7	Full	2.1	23	Genital symptoms – even though this is symptoms, all children need to be asked re CSA with such symptoms. Also allegations need to be heard. Also some present with bruising to thighs, buttocks, lower abdomen i.e. CSA presenting with physical abuse/injury	Thank you for this comment. The emphasis in the guidance is on observing an indicator and either 'considering' or 'suspecting' maltreatment. All of your points are dealt with in the actions associated with 'consider'.
SH	Camden PCT	8	Full	2.1	24	Pregnancy in age 13-15 also add "unless it is consensual intercourse i.e. between a 14 and 15 year old"	Thank you for your comment. The situations are different because of the different stigmas associated with STIs and pregnancy and therefore the greater possibility of concealment of the true father.
SH	Camden PCT	9	Full	2.1	24	Neglect – not in order of importance and how frequently seen by a paediatrician e.g. DNA is important and should be at the top	Thank you for this suggestion. We have been working with the editorial team at NICE to decide how best to present these recommendations.
SH	Camden	10	Full	2.1	25	FII – "spectrum" needs to be added here.	Thank you for this suggestion. FII spectrum is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	PCT						not current terminology and so it is not used in the guideline.
SH	Camden PCT	11	Full	2.1	27	Wetting and soiling – add CSA as a cause – very rare.	Thank you for your comment. The GDG chose not to list specific types of maltreatment here because more than one type can cause these signs.
SH	Camden PCT	12	Full	2.1	28	Inserting object/finger into their own vagina as well as other children?	Thank you for this suggestion. We have provided a list that is not exhaustive, so your point is implicit in our recommendation, although there was some concern within the GDG that this behaviour can be part of normal developmental exploration.
SH	Camden PCT	13	Full	3.1	33	In paragraph on "consider" maltreatment. Mention that it may not only be one of the differential diagnoses but can co-exist with a condition e.g. scabies or diabetes etc.	Thank you for this suggestion. The following sentence has been added: "Indicators of maltreatment can co-exist with organic disorders."
SH	Camden PCT	14	Full	3.1	34	When maltreatment is considered aren't local procedures also followed? This should be near the beginning of the document.	Thank you for your comment. It is true that local guidance should be followed at the 'consider' level but the GDG believes that such guidance is not specific enough for their purpose so has used this only in 'suspect'.
SH	Camden PCT	15	Full	3.1	34	cultural practice – "a small number" is not very helpful. Why not say culture practice "can never be a reason for maltreatment. The practice can be discussed with a colleague from that culture if in doubt e.g. co-sleeping - which ages is this acceptable i.e. 3 or 4 year old versus 13 and 14 year old.	Thank you. This statement has been amended to ensure clarity.
SH	Camden PCT	16	Full	All	many	rather than "health professionals, should call" ..... why not write "call"? This would rid the document of repeating "health professionals should ....."	Thank you for this helpful suggestion. NICE's editorial style was recently revised and now fits the style you suggest so all recommendations are now presented in that style.
SH	Camden PCT	17	Full	4.1	37	Are the recommendations from CDG or from GDG and Welsh Systematic review? It needs	Thank you for your comment. The guidance has been drawn together using the standard

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						to be clear. May be it could be said in 1.1 P.14 in the introduction chapter.	NICE approach to evidence identification and critical appraisal and drawn into recommendations. One of the evidence sources was the Welsh Child Protection Systematic Review Group work. This was presented to the GDG to inform recommendations as stated in methodology section 1.4. Where evidence was not available, the Delphi consensus approach was followed.
SH	Camden PCT	18	Full	4.1.2	37	No link with animal bites to maltreatment but there is a link between maltreatment of animals and children	Thank you for raising this. We have added animal abuse to the list of risk factors in Chapter 3.
SH	Camden PCT	19	Full	4.1.4	41	Can one assume that recommendations are from GDG and Welsh Systematic Review?	Thank you for your comment. In the preceding paragraph, it is stated that the GDG concurs with the recommendations of the Welsh systematic review group.
SH	Camden PCT	20	Full	4.1.4	43	Rib fractures – no mention of CPR here, is there a reason?	Thank you for your comment. We have not looked at non-abusive causes of injuries unless they are mentioned in comparative studies.
SH	Camden PCT	21	Full	4.2	53	No reference number given for the 2 additional case series, I assume it is 33 and 34?	Thank you for highlighting this. That is correct. The references have been added.
SH	Camden PCT	22	Full	5.1	64	How many children in Newcastle study i.e. what % were involved with social care?	Thank you for your comment. Twenty-two percent of families were involved with social care. This has been added to the text.
SH	Camden PCT	23	Full	5.3	69	If a child presents for dental extraction because of caries are they more likely to have suffered some type of maltreatment compared with children coming for routine dental treatment?	Thank you for your comment. This depends on the extent of dental caries and how long the condition had existed before the parent/carer took action. The GDG has opted for 'consider' here, thus enabling the health professional to examine the circumstance of the presentation.
SH	Camden PCT	24	Full	6.1	71	Surely attendance could be due to symptoms from maltreatment such as deliberate self	Thank you for your comment. This is a valid possibility; self-harm is covered in Chapter 7.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						harm?	
SH	Camden PCT	25	Full	7.1	71-82	Table should include "after witnessing DV (now known as IPV) and CSA – child sexual abuse. it is not clear as table is in the middle of the explanation and discussion.	Thank you for your comment. Domestic violence is covered in chapter 8. The guidance focuses on indicators in the child rather than the cause.
SH	Camden PCT	26	Full	7.1	86	In this section e.g. P86 line 1, mention the coexistence of medical conditions AND an emotional/behaviour disorder	The GDG is unsure about the meaning of this comment.
SH	Camden PCT	28	Full	All	Title	Should it be called "when to suspect or consider child maltreatment"?	Thank you for this suggestion. The title of the guidance is set in the scope and cannot be changed.
SH	Camden PCT	29	Full	2.1	20	There needs to be a paragraph on difference between "suspect" and "proof". Does "proof" mean beyond all reasonable doubt as judged in a criminal court? Is proof of a subdural when a perpetrator tells you he/she threw the child against the wall and hit his/her head?	This guidance is not about proving maltreatment, and in the operational definition of 'suspect', we state that this means serious concern about the possibility of child maltreatment but … not proof of it.
SH	Camden PCT	30	Full	2.1	24 continued	lines 11/12 isn't pregnancy under 13 years proof?	Thank you for your comment. Proving maltreatment is outside the scope of the guidance.
SH	Camden PCT	31	Full	3 and 7		Generally not enough awareness of overlap of types in "clinical awareness" and Ch 7 when many children who allege sexual abuse can be labelled as emotional abuse and the sexual abuse not acknowledged.	Thank you for your comment. The document's emphasis is on the indicators that raise suspicion and not the type of abuse. The 'labelling' to which you allude is outside the scope of the guidance.
SH	Camden PCT	32	Full	All		There is evidence for PTSD in maltreatment - see Gilbert R et al Lancet 2008 and is not mentioned here. The guidelines need to take the evidence from the Lancet series into account.	Thank you for this comment. The GDG, while not considering the diagnosis of PTSD as an indicator of maltreatment, has considered the elements that constitute PTSD. Consideration of these elements can be found in the recommendations about behaviour and emotional states.
SH	Department of Health	1	NICE	General	General	Where abuse or neglect is *suspected,* we feel that all doctors should be aware of referral	Thank you for commenting on this draft guidance and your acceptance of it.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						pathways to those who have the skills to assess children, and that all paediatricians must be able to assess children. The word *"suspect"* is important because it generally triggers referral. The guideline also distinguishes situations in which maltreatment is *considered,* i.e. not suspected. We believe that this is an important distinction, because the professional's response may be to gather information personally, rather than to share or refer it. It would be helpful if the words *"suspect"* and *"consider"* were highlighted throughout the guideline. Although these words are clearly defined in section 1.1, we feel that a user (who is not familiar with the guideline, or who reads a section rather than the whole text) may not properly grasp the way in which the words are meant to be used.	We have been working with the editorial team at NICE to identify the best way to highlight the importance of understanding consider and suspect and have taken note of your suggestion.
SH	Department of Health	2	NICE	General	General	Could you please consider converting Appendix "C" into Appendix "A". We believe that this is a very useful algorithm, which could easily be missed.	Thank you for your comment. The layout and presentation of the NICE guideline is determined by NICE. However, we will refer to appendix C within the main text that describes suspect and consider.
SH	Department of Health	3	NICE	General	General	It would be useful if cross-reference could be made to the *Information Sharing Pocket Guide* (published by HM Government).	Thank you. This has been added to the list of relevant documents.
SH	Department of Health	4	NICE	General	General	There is currently no recognition of the links between parental mental health problems, substance misuse and learning disabilities as risk factors. In our opinion the danger is that by not including them, it sends a message that	Thank you for your comment. The specific exclusion of these topics was set out in the scope. These areas are now acknowledged in the introduction to the guideline.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						they are not relevant when, in all the reviews of children who die or are seriously injured, there is a very high incidence of these.	
SH	Department of Health	5	NICE	1.2.4	9	Could you please consider the inclusion of some examples of cultural practices which may be considered to be "abuse".	Thank you for this suggestion. The GDG's view is that mentioning specific (and self-evidently) harmful practices has the potential to detract from the general message.
SH	Department of Health	6	Both	1.6.9 and 7.2.5	24 and 97	These sections appear to suggest that selective mutism is commonly associated with maltreatment. We feel that there is a need to include some reference to the usually underlying cause being an anxiety disorder that is not related to trauma.	Thank you very much for this comment. The GDG acknowledges this was an area where we have been able to consider the issue afresh as result of your comment and the recommendation has been removed.
SH	Department of Health	7	Full	2.1	24	'Clearly untreated caries in children can lead to pain and suffering and may reflect neglect in other areas of the child's life as well. However, access to dental services (as the child may be in pain), may be the only access to health care professionals for that child. There is concern that this guidance may deter parents or carers from seeking dental care if they feel this could lead to a referral from the dentist for neglect. So whilst recognising that this is an important issue, we feel there needs to be clarity around the wording of the guidance.	Thank you for your comment. The guidance is for health care professionals, not for parents. The health professional would need to show the usual sensitivity when explaining possible consequences.
SH	Department of Health	8	Full	5.3	69	It would be helpful if 'persistent failure' to obtain treatment could be more clearly defined. If left to individual interpretation this could potentially lead to referrals for children having missed two appointments for routine fillings. Wording should make it clear that persistent failure should be monitored over a period of time, and the child's oral health should be such	Thank you for your comment. A persistent failure would be observed when a child has visibly poor oral hygiene and the parents have failed to act upon it.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						that it gives rise to concern over the general welfare of the child. The Department has produced a child protection leaflet which may also be of value, the link to this is: http://www.cpdt.org.uk/f_info/dload_0.htm'	
SH	Education Otherwise Association Limited	1	Full	General	General	My organisation Education Otherwise is a registered stakeholder. Education Otherwise is a membership organisation which supports home educating families and promotes awareness of home education. We have around 4,000 members who subscribe to our newsletters. In addition we run a telephone helpline and have a network of local contact throughout England and Wales. I am responding to this consultation on behalf of Education Otherwise Disability Group. The contact address for the Disability Group is : disabilityawareness@education-otherwise.org	Thank you for commenting on this draft guidance.
SH	Education Otherwise Association Limited	2	Full	General	General	We note that maltreatment has been defined as including "neglect, emotional abuse, physical abuse, sexual abuse and fabricated or induced illness, alone or in combination" Whilst we welcome guidance which puts the child at the centre, we have concerns in several areas related to home education which we believe stem from the fact that home education is not widely understood. We make no apologies for repeating the word	Thank you for your comments.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						"pathologised" since we have a great deal of feedback from our members reflecting that they risk being pathologised when they try to protect their children.	
SH	Education Otherwise Association Limited	3	Full	General	General	Firstly, we are aware of instances where it is alleged that home education itself is emotional abuse, ie that the parent is using the child to meet his or her own emotional needs. This allegation sometimes arises during disputes between separated parents and sometimes is made by members of the children's workforce who have not received any information or training about home education. In short, home education itself is pathologised and the parent is pre-judged. There are few Independent Expert Witnesses in this field. One such witness is Dr Paula Rothermel. We would be happy to put lead professionals in contact with Dr Rothermel. We are already speaking to DCSF and to the Children's Workforce Development Council about this issue and it will be cited in the Position Paper which Baroness Morgan has requested from Education Otherwise. We also attempt to address it at local level when it is brought to our attention. In addition we are speaking with the National Autistic Society who tell us that their helpline is receiving an increasing number of enquiries about home education. A representative from Education Otherwise Disability Group will be speaking at a forum of NAS helpline volunteers	Thank you for this information and for commenting on the draft guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						in April. We will be sending a copy of this consultation response to NAS.	
SH	Education Otherwise Association Limited	4	Full	General	General	As an organisation, Education Otherwise is able to give information about home education. Clearly, we would not take enquiries about specific families, but we feel it would be beneficial for NICE to signpost members of the children's workforce to Education Otherwise in order that we can answer general questions about the principles and practice of home education and make it clear that home education is not in itself a cause for concern. This position is clearly stated in DCSF guidelines on Home Education and in statutory guidance on Children at Risk of Not Receiving Suitable Education but is still not widely understood. We would be extremely grateful if the final published guidance from NICE could signpost Education Otherwise as a source of information for lead professionals about home education. We can be contacted via the contact form on our website, or via our Enquiries number 0845 4786345 or by post at: PO Box 325, St Germans, Kings Lynn, Norfolk PE34 3XW in addition to the Disability Group email address given earlier. http://www.education-	Thank you for this comment. We will pass it on to the Public and Patient Involvement Programme at NICE who are responsible for signposting readers to other organisations.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						otherwise.org/contact.php	
SH	Education Otherwise Association Limited	5	Full	General	General	Secondly, we believe there are issues around special needs which are not adequately addresses by the guidance in its present form. Some of the symptoms of autistic spectrum disorder in the child could present as emotional abuse on the part of the parent. There are specific problems for home educating parents in this regard. ASD children are frequently bullied at school, which is a contributory factor to children being taken out of school to be home educated. There is a danger that the behaviour of children who are traumatised following bullying will be misinterpreted by professionals and that suspicion will fall automatically on the parents. We are aware of a number of cases where this has happened. Prejudice and misinformation on the part of the lead professional may be compounded by any elements of special needs, learning difficulties or communication disorder on the part of the child. The parent is caught in the middle and it is the parent who risk being pathologised.	Thank you for your comment. According to our recommendations, neurodevelopmental problems such as autistic spectrum disorders should be excluded before considering child maltreatment in children who show emotional and behavioural indicators of maltreatment. NICE has commissioned a guideline on autistic spectrum disorders in children and young people and you may wish to follow its progress at: **http://www.nice.org.uk/guidance/index.jsp?action=download&o=36206**
SH	Education Otherwise Association Limited	6	Full	General	General	Furthermore, with reference to factitious or induced illness, we need to highlight that there is a particular issue in home education with getting a diagnosis of autism. It is hugely under-diagnosed. In cases where the parent attempts to get a diagnosis of special needs for the child, we have again seen that the parent is pathologised. In some cases the local authority contests the need for additional	Thank you for commenting on this draft guidance. Your concerns have been noted. NICE is developing a clinical guideline on initial recognition, diagnosis and referral of autistic spectrum disorders in children and young people and we suggest you register as a stakeholder for that guideline if you have not already done so (see **http://www.nice.org.uk/Guidance/CG/Wave1**

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						support and the application is unsuccessful. In other cases the child has found the assessment procedure too traumatic for the family to continue. Another reason for lack of diagnosis is that there is no benefit in diagnosis once a family is home educating since any additional support is not forthcoming due to lack of funding. We welcome the opportunity to comment in general terms on the draft guidance. Please contact Education Otherwise for any further information.	**5/78)**
PR	H Dubowitz	1	Full		12, line 54	Frenulum?	Thank you for your comment. The term agreed by the GDG to refer to this part of the anatomy is frenum.
PR	H Dubowitz	2	Full		13, 39	articular	Thank you for highlighting this.
PR	H Dubowitz	3	Full		14, 2	Heading doesn't fit	This has been changed to "Background to the guidance"
PR	H Dubowitz	4	Full		23, 20-40	Would cluster those under "consider."	Thank you for this comment. These decisions were reached after careful consideration by the GDG.
PR	H Dubowitz	5	Full		23, 37	Would define "gaping." Here and elsewhere, the details are key.	This term has been added to the glossary.
PR	H Dubowitz	6	Full		24, 48	Will abandonment be defined elsewhere?	Thank you for your comment. Abandonment means leaving a child alone or with an inappropriate carer. This has been added to the glossary.
PR	H Dubowitz	7	Full		29, 22	Prospective study of FII? Would be v. tricky with low base rate.	Thank you for your comment. This is true; your comment has been noted.
PR	H Dubowitz	8	Full		40, 41	Would suspect rather than consider	Thank you. We have carefully defined consider and suspect as and when they are used in the recommendations. We have used the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							expressions used by authors of included studies in our summary of evidence. However, as you point out there is potential confusion here. We have sought editorial advice to overcome this issue.
PR	H Dubowitz	9	Full		41, 35	Agree, here it is suspect	Thank you.
PR	H Dubowitz	10	Full		41, 37, 40	Non-inflicted contact with a hot iron can still leave an elliptical burn, with sharp edges. Common in the US	Thank you for your comment. We hope that this recommendation is qualified by the fact that the contact burn is "on areas that would not be expected to come into contact with hot object in an accident etc" The recommendation itself does not describe the degree of demarcation of the burn.
PR	H Dubowitz	11	Full		38, 17	Smaller child's arch can quite often be discerned from that of an adult	Thank you for your comment. Comments from the Delphi panel and other stakeholders suggest that it is not so easy to make that distinction.
PR	H Dubowitz	12	Full		40, 38	Suggest replacing "accidental" with "non-inflicted." The former implies a randomness which is generally not the case.	Thank you for your comment. We appreciate that there is a balance that needs to be struck between the intended audience of this guidance (health professionals and interested lay people) and the academic community. We will be working with our editor to ensure that the term 'accidental' is used appropriately.
PR	H Dubowitz	13	Full		41,4-8	Would begin with most important points. Some seem questionable (eg, unrelated adult – would need to assess the circumstances. Might be better to state "psychosocial red flags" and give some examples.	Thank you. This section is a summary of evidence that was available to inform the recommendations. But as you point out when considered by the GDG these points were not felt strong enough indicators on their own, more akin to risk factors that were outside the scope.
PR	H Dubowitz	14	Full		41, 9	Which review? The criticism levelled in this paragraph is possibly too rigid. Some/many of these issues are not amenable to the kind of	Thank you for this. To a certain extent, we are bound by NICE's criteria for review quality.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						study suggested. Would be careful to balance the quest for scientific rigor with a realistic appraisal of what can be gleaned from experience and plausible mechanisms.	
PR	H Dubowitz	15	Full		41, 40	Non-inflicted burns can still produce a patterned elliptical burn with clear borders.	Thank you. I hope we have addressed your concerns above.
PR	H Dubowitz	16	Full		43, 22-32	What about location of rib fractures, with posterior and to some extent lateral being more suggestive of abuse. I think the evidence is more solid re. these fractures in infants.	Thank you for this suggestion. We had attempted not to be too specific about fracture site or type. We would hope that front line healthcare professionals would raise a suspicion of abuse in any unexplained fracture in a child under 18 months as described in the recommendations, whereas the detail of the fracture would be more carefully considered during further assessment of the case
PR	H Dubowitz	17	Full		43, 39	In pre-ambulatory infants, this percentage is likely higher. Need to factor in development. The percentages offered, here and elsewhere, are thus low for the most concerning circumstances. And, there are potentially serious consequences of how this could be interpreted. For eg, a 2-month old with such a fx could be said to be more likely due to an "accident" than abuse.	Thank you, we agree. The material presented is a summary of evidence and the authors of the systematic review point out the difficulty of allowing for age in their meta-analysis. We have added a sentence to highlight this. We hope that the points made in the bulleted section lower down point out the increased concern in the younger children.
PR	H Dubowitz	18	Full		44, 11	Again, this rate is problematic without consideration of development, circumstances. In an infant not yet rolling over, clearly more of these fractures suggest abuse.	See above.
PR	H Dubowitz	19	Full		44, 15	This does not do justice to Kleinman's research	Thank you. We are aware of the studies by Kleinman. However, these were not comparative studies and therefore do not explore our ability to determine the discriminatory powers of metaphyseal fractures for abuse. Kleinman's work is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							particularly focused around the pattern of metaphyseal fractures and comparison between radiological and post mortem features. This work is more relevant to the detailed assessment of a child with suspected abuse by the clinical child protection team which is outside the scope of this guidance. We hope that front-line professionals would identify concern for any unexplained fracture in the infant age group as described in the recommendations.
SH	Healthcare Commission	1	Full	General	General	The Healthcare Commission welcomes this draft guidance for consultation on 'When to suspect child maltreatment'. As the regulator of healthcare in England, we play a key part in checking that NHS trusts and independent providers safeguard the children and adults who use their services. Our work to help protect children and vulnerable adults and to promote their welfare includes monitoring how well healthcare organisations are complying with standards and statutory responsibilities for safeguarding and it is anticipated that when reviewing our lines of enquiry for Core Standard 2 we will use these guidelines as a reference and develop them accordingly.	Thank you for commenting on this draft.
SH	Healthcare Commission	2	Full	General	General	From April 2009, the Care Quality Commission will take over the work of the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission, and will consider guidance for	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						use in registration requirements for healthcare organisations.	
SH	Healthcare Commission	3	Full	General	General	The Healthcare Commission has been asked by the Secretary of State to undertake a swift review of the arrangements relevant NHS organisations have in place to ensure they are meeting obligations with regards to safeguarding children. This will look at board assurance around child protection systems, including governance arrangements; around training and staffing; and around arrangements for health organisations to work in partnership with others to safeguard children. It is anticipated that the findings of the review will be published in June – July 2009. With the NICE guidelines due for publication in July this will come at a good time for healthcare professionals looking to improve the way they work in relation to safeguarding and the NICE guidelines will enable them to achieve this. The raised awareness of safeguarding due to these publications and several others (from DCSF, Lord Laming) will raise the profile of child protection and safeguarding resulting in positive improvements from all involved agencies.	Thank you for your comment. We look forward to publication of the Healthcare Commission's review and agree that this should add to the level of awareness of child protection issues.
SH	Healthcare Commission	4	Full	General	General	The Healthcare Commission would welcome the development of further guidance on child maltreatment. Whilst outside of the scope of these guidelines, the development of guidelines on the treatment and care of children if maltreatment is suspected, as well as how professionals should proceed once	Thank you for your comment. We will pass this comment on to the commissioning team at NICE.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						they have come to suspect maltreatment would be welcomed and be invaluable in helping healthcare professionals to safeguard children.	
SH	Healthcare Commission	5	Full	2.1	20-21	The Healthcare Commission welcomes the reference to cultural issues in child maltreatment. This section states: Healthcare professionals should be aware that some child maltreatment may be explained as, or mistaken for, cultural practice; a small number of cultural practices are harmful to children. Healthcare professionals should act appropriately when considering or suspecting maltreatment even when they have an understanding of the background and reasons why the maltreatment might have occurred and even when there was no intention to harm the child. This is an important issue and perhaps needs more space dedicated to it to advise on other issues in relation to: - Language as a factor which can inhibit the recognition of child abuse. The need to use independent and professional translators to discuss issues with the child rather than relying on a parent for translation. - Female genital mutilation. This was not mentioned at all in the guidance, yet healthcare professionals need to be aware of the issues surrounding this and be	Thank you. Language as a factor is covered in the section about communication. Readers are now referred to supplementary guidance to Working Together, including that on female genital mutilation.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						able to recognise this form of maltreatment.	
SH	Healthcare Commission	6	Full	1.4	15	The guidance states 'In addition this guidance may be of interest to professionals working in social services, education/ childcare settings', We would recommend the addition of another part to the sentence so that it reads: 'In addition this guidance may be of interest to professionals working in social services, education/childcare settings ***and in independent healthcare'***.	Thank you for this suggestion. "and in the independent health sector" has been added.
SH	Hertfordshire Partnership NHS Foundation Trust	1	General			I was looking at this briefing and I was disturbed to note that in the bit about recognition of child abuse there wasn't a section on over-intrusive caretaking. This would cover a lot of our over-anxious mothers and particularly those with OCD type conditions. Neglect also needs further description in terms of poor boundary setting, lax moral standards etc.	Thank you for commenting on this draft. Over-intrusive care-taking is covered in developmentally inappropriate expectations of the parent on the child.
SH	Institute of Work, Health & Organisations (I-WHO) University of Nottingham	1	Full	General		My Comments are: There should be more emphasis on social and behavioural indicators, especially for use by Health visitors and primary health care teams. I have attached the WHO guidelines on risk assessment and prevention (See algorithm for use by A&E staff) produced by the WHO Collaborating Centre on Child Care and Protection at Birmingham which I head. You should also refer to the 'UN Secretary General's Report on Violence to Children' (just Google this title for full docs).	Thank you for your comments on this draft and for submitting the attached articles. As you will be aware, social indicators of maltreatment are outside the scope of this guidance, as is prevention of maltreatment. The GDG agrees that social indicators are important in the identification of maltreatment and suggests that you submit this as a theme for future NICE guidance. (**http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp**)

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Also see findings and evaluation of a three year sure-start programme in Essex. Therefore I have attached chapter 3 (Index of Need) and chapter 10 (Programme Evaluation) exerts which deal with identification from a social behavioural perspective by health visitors . These Chapters are from the book 'A COMMUNITY HEALTH APPROACH TO THE ASSESSMENT OF INFANTS AND THEIR PARENTS' By K Browne et al (2006) J. Wiley.	
SH	Joint Royal Colleges Ambulance Liaison Committee	1	Both	General	General	This clearly is an important document, and no doubt reflects the importance Safeguarding Children so rightly deserves.	Thank you for commenting on this draft.
SH	Joint Royal Colleges Ambulance Liaison Committee	2	Both	General	General	The guidance is thorough and comprehensive, but given the groups of health professionals for whom it is intended 'the Non-Paediatric Specialist (see 1.4: *professionals who may encounter children in the course of their professional duties*)', we feel, in its current format the guidance is not very accessible to these frontline health professionals. We would suggest tailoring the maltreatment advice to specific "user-groups" detailing specifically their roles and responsibilities. For example, whilst the draft document details standards suitable and appropriate for a consultant	Thank you for this suggestion. The developers have been unable to take this approach in the recommendations because so many of the indicators would appear in several categories and be repeated. In addition, indicators for maltreatment may be seen by groups of people who may not normally expect to observe them and for these reasons, this approach has not been taken in the Full version of the guideline.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						paediatrician, these standards would be above those expected from an ambulance technician or paramedic, who would benefit from a simplified approach such as a checklist, when suspecting child maltreatment. A good example of this approach is utilised in the *Guidelines on 'Feverish Illness in Children,'* where the GDG helpfully assigned certain chapters to three specific user-groups: (1) Remote Assessors (2) Non-paediatric Practitioners (3) Paediatric Practitioners, assigning roles appropriate for each. JRCALC welcome the proposed Quick Reference Guide to accompany this guideline, but stress the importance of targeting this to specific 'user-groups'.	
SH	Joint Royal Colleges Ambulance Liaison Committee	3	Full	2.1 - *Points for clinical practice*	Page 20 lines 42-43	Could the GDG consider clarifying the wording of this sentence on cultural practices which is confusing? I have been involved with children abused in a "cultural setting" and I wonder whether this sentence could be clearer in stating this possibility?	Thank you. This section has been amended to ensure clarity.
SH	Joint Royal Colleges Ambulance Liaison Committee	4	Full	2.1 - *Definitions of maltreatment*	Page 21 Lines 12-17	within "Working Together…" on page 35, the categories "Physical, Emotional, Sexual and Neglect" are used as *Definitions of Maltreatment*. Since Chapter 2 is intended to be a **Summary of recommendations and care pathways**, these 4 categories must surely be listed in this summary.	Thank you for your comment. Chapter 2 presents all of the recommended actions for healthcare professionals. The definitions of maltreatment as per the English version of Working Together are listed later in this document.
SH	London Ambulance Service NHS	1	NICE	General	General	It would be useful to highlight in bold "suspect" and "consider" within the document. The specific definitions are important and this	Thank you for this suggestion. We have been working with the editorial team at NICE to identify the best way to highlight the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust					would aid readers in following the document more easily.	importance of understanding consider and suspect and have taken note of your suggestion.
SH	London Ambulance Service NHS Trust	2	NICE	1.1.2	Page 8	Highlight in bold the statement "No further action is not an option if maltreatment is considered". This will emphasise the point being made.	Thank you for this suggestion. We have been working with the editorial team at NICE who have advised us on such matters of presentation.
SH	London Ambulance Service NHS Trust	3	NICE	1.1.2	Page 8	The third bullet point states "review the child at a later date…." Although reasonable, a caveat should be added that this is only an option when robust follow-up arrangements are in place and either the same clinician, or someone properly briefed, will be involved. There should be a responsibility placed on health care professionals to ensure information that abuse has previously been considered is available to other professionals and agencies that may subsequently come into contact with the child. Learning from previous investigations shows that the absence of this history can hinder the identification of abuse.	Thank you for this comment. This sentence has been amended to: "ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting feature." in the light of your comment. We hope this is helpful.
SH	London Ambulance Service NHS Trust	4	NICE	1.2.6	Page 9	This statement may benefit from some expansion or with a reference to other sources of information which would provide more specific guidance and advice for practitioners.	Thank you for your comment. This is outside the scope of the guidance.
SH	London Ambulance Service NHS Trust	5	NICE	1.3.5	Page 11	A specific type of mark or scar which could be usefully highlighted here is those that may have been made by a buckle, inflicted during a beating.	This type of mark is covered under 'cuts, abrasions or scars that are in the shape of an implement'. Giving specific examples could detract from the general message.
SH	London Ambulance	8	NICE	General	General	Apart from an implicit reference within the sections on fabricated and induced illness,	Thank you for your comment. Whilst an important observation, parental behaviour on

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Service NHS Trust					there is no mention of the need for healthcare professionals to be alert and aware of the propensity of some abusers to be skilled in obfuscation and manipulation of professionals. A general statement to this effect would be helpful.	its own .is not within the scope of this guideline.
SH	Medical Defence Union	1	NICE		6	Our comments relate to the advice on page 6 to healthcare professionals who suspect child maltreatment. We agree that they should consider the document 'Working together to safeguard children', but they also need to take into account specific guidance published by their regulator. In the case of doctors that is guidance produced by the General Medical Council on Confidentiality and also its specific guidance for young people from 0-18 years. The paragraph also suggests that healthcare professionals should obtain advice from designated or named professionals. Very often in such circumstances they also seek advice from their medical defence organisation and you may wish to mention this in the final guidance	Thank you for your comment. The GDG does not intend that this guidance should replace guidance from regulatory bodies. We recognise the importance of the guidance noted in your comment.
PR	NCCHTA 1	1	Full	General		**Q1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** One aim of this guideline is to raise awareness of the clinical features of child maltreatment. As evidence on physical features for child maltreatment is limited, this guideline will inform researchers and highlight the	Thank you for your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						importance of further investigations in the associations between clinical features and the risk of child maltreatment. The findings from further research will in turn provide evidence for updating the guidance.	
PR	NCCHTA 1	2	Full	2	20-31	**Q1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** The main aim of this guidance (stated in the Scope) is to provide a concise summary of the major physical features associated with child maltreatment. However, Section 2 gives a detailed list of physical features which are repeated in the subsequent sections (4-8).	Thank you for your comment. It is established practice to reproduce the complete list of recommendations at the beginning of the full guideline document; this summary corresponds to the NICE version.
PR	NCCHTA 1	3	Full	2.1	22	**Q1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** In the Scope the authors excluded the diagnostic assessment (i.e. X-ray). But in Sections 2.1 and also 4.17 (page 46), X-ray evidence for fracture is used in the recommendations.	Thank you. The diagnostic assessment involves detailed X ray assessment. However, some front line healthcare professionals may identify a fracture on a routine X ray on the wards, in accident and emergency or as radiographers.
PR	NCCHTA 1	4	Full	General		**Q2 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** The guideline is mainly based on the evidence	Thank you for your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						from existing literature and GDG consensus. Delphi consensus process is used in areas where there is a lack of literature on the clinical features of child maltreatment, or when there is no GDG consensus and requiring external validation. This process is a valid approach.	
PR	NCCHTA 1	5	Full	General		**Q2 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** One general comment is that although all these physical features given in this guideline are potential indicators for child maltreatment, the severity and the number of the features are also important to identify children with the highest risk.	Thank you for your comment. Indeed this is true, but a single indicator can be enough to raise the correct level of suspicion. Once maltreatment has been suspected based on a single indicator, the level of suspicion can be assessed in terms of risk.
PR	NCCHTA 1	6	Full	1.7	18	**Q2 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** As stated in the Scope, the guideline should provide a concise summary of clinical features so it is not ideal to include too many recommendations. On the other hand, missing out important features might have serious implications. Thus the choice of the cutoff at	Thank you for your comment. The choices for the cut-off and the values were decisions made such that the GDG would be confident that their opinions were supported or refuted. The rules for the process state that the GDG has permission to overrule the Delphi panel. We have stated this in all instances where this has happened and used the 'free text' comment to inform our choices.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						75% (i.e. 75% panel members scored >7) for the Delphi consensus should be explained. The cutoff will affect whether a specific clinical feature should be included in the guideline. It will be useful to apply the Delphi consensus process to the recommendations that are chosen based on the evidence from the literature, to assess the consistency of the results and to validate the cutoff point of 75%.	
PR	NCCHTA 1	7	Full	5.1	64	**Q3 Please comment on the health economics and/or statistical issues depending on your area of expertise.** From a longitudinal study of 352 low birth weight infants (ref 35), the authors conclude that the impaired cognitive development is ''a consequence of neglect in extreme low birth weight infants''. This statement is too strong. It would be reasonable to say '' the evidence suggests that there is an association between childhood neglect and impaired/delayed cognitive development''.	Thank you for this clarification. This change has been made.
PR	NCCHTA 1	8	Full	General		**Q4 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** Because of the lack of evidence or inconclusive findings for many clinical features for child maltreatment, many recommendations are based on GDG consensus. Their arguments are generally reasonable. However,	Thank you for this interesting suggestion. A categorisation such as this would be difficult to achieve since all recommendations are ultimately based on GDG consensus even though there are different types of evidence that inform them. The 'GDG considerations' sections aim to clarify the links between the evidence (where it exists), the GDG's interpretation of the evidence and/or Delphi consensus, and the final recommendations.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						it will be informative to provide a summary on the numbers (or %) of recommendations that are based on the evidence from literature, the GDG consensus, and the Delphi consensus process, or a combination of two approaches.	
PR	NCCHTA 1	9	Full			**Q5 Are any important limitations of the evidence clearly described and discussed?** No comments given	No response required.
PR	NCCHTA 1	10	Full	General		**Q6 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** The report is reasonably well presented. There is detailed information on how the recommendations have been reached. However there are several areas can be improved.	Thank you for commenting on this draft.
PR	NCCHTA 1	11	Full	2.1	20-28	**Q6 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** The sub-sections ''Chapter 3 …'' to ''Chapter 8 …'' in Section 2.1 are confusing. The authors should clarify that these are the summary of the recommendations listed in the Sections 4 to 8 and details of how they are developed are given later.	Thank you for your comment. We will work with our editor to ensure this is clear.
PR	NCCHTA 1	12	Full	2.3	29-30	**Q6 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to**	Thank you for your comment. We will work with our editor to eradicate this duplication.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						understand how the recommendations have been reached from the evidence. Section 2.3 is duplicated in section 2.2, should be removed.	
PR	NCCHTA 1	13	Full	2.4	30-31	**Q6 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** The flow chart should be moved to page 20 or 21 as the Section 2.1 explains the pathways illustrated in the chart.	Thank you. We will give this due consideration and will raise it with the editor.
PR	NCCHTA 1	14	Full			**Q7 Please comment on whether the research recommendations, if included, are clear and justified.** No comments given	No response required
PR	NCCHTA 1	15	Full			**Q 8 additional comments** No comments given	No response required
PR	NCCHTA 2	1	Full	General		**Q 1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)** No gaps noted	No response needed.
PR	NCCHTA 2	2	Full	General		**Q 2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).** The methods were extremely transparent, clearly articulated and appropriate to the aims	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						of the guidance	
PR	NCCHTA 2	3	Full	1.7	19	**Q 2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.** Economic evaluation was considered inappropriate given the scope of the guidance and I would agree with this assessment. However, it is naïve to justify the exclusion of an economic evaluation on the grounds that interventions are not being compared. Economic evaluation is a tool to aid decision making between two actions (not necessarily two interventions) which can indeed be decision making processes, such as guidelines to detect maltreatment, which will involve differential costs (and benefits). A more appropriate justification is that it is too early in the stages of evaluation, since you can't evaluate a policy change that has not yet been formulated. Very pedantic, I know, but there was little else to criticise in this excellent document!	Thank you for your comment. However, the section that is being referred to actually describes economic evaluation as a comparison of 'different alternatives' in order to aid 'clinical decision making between different courses of action'. It does not justify the exclusion of economic evaluation on the grounds that 'interventions are not being compared' and does not use the term 'intervention'.
PR	NCCHTA 2	4	Full	General		**Q 3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?** Overall, the authors present very clear and well justified recommendations and are careful to stress areas where little or poor quality evidence exists and to make research recommendations where appropriate.	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
PR	NCCHTA 2	5	Full	General		**Q 3.2 Are any important limitations of the evidence clearly described and discussed?** No limitations of the guideline development process are discussed. I do not have any specific concerns as the methodology employed seemed entirely appropriate. However, the authors are probably more aware of any limitations (particularly the areas where evidence was poor) and a clear statement would be helpful to highlight those areas where recommendations are perhaps weaker.	Thank you for your comment and support for the methodology used. The "GDG considerations" sections highlight how conclusions have been reached and where there was little or no evidence on which to base recommendations.
PR	NCCHTA 2	6	Full	General		**Q 4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** Very clear, well presented and accessible.	Thank you.
PR	NCCHTA 2	7	Full	General		**Q 4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.** It is rather confusing to have Appendix A, B and C in the main guideline and completely different appendices included as separate documents that are also called A, B and C.	Thank you for highlighting this. We will ensure that this does not recur in the final version of the guideline.
PR	NCCHTA 2	8	Full	General		**Q 4.2 Please comment on whether the research recommendations, if included, are clear and justified.** Research recommendations are clear and well justified.	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
PR	NCCHTA 2	9	Full	General		**Q 5 additional comments** None	No response required.
SH	NHS Direct	1	Full	1.1. row 7	14	A reference to the figures of referrals would be valuable for validating	Thank you. This has been added.
SH	NHS Direct	2	Full	1.2. row 37	14	The reference used in Appendix C re Formal Delphi consensus method would be of value here	Thank you. This change has been made.
SH	NHS Direct	3	Full	1.3. row 6	15	Communicating to parents is difficult especially for the target group being to those who are not cp specialists. Should this be looked at or a link to guidance elsewhere?	Thank you for your comment. Communicating with parents about suspicions is outside the scope of this guidance.
SH	NHS Direct	4	Full	2.1	20-21	Summary of recommendations. Clear language used in these bullet points, I found these very helpful	Thank you.
SH	NHS Direct	5	Full	2.1 row 43	23	Would a reference to Sexual Offence Act 2003 be appropriate here. It is introduced later on pg 62 4.2.4	Thank you for this suggestion. Cross-references have now been added.
SH	NHS Direct	6	Appendices	C 2.7	120	Reducing obesity in children is an accepted target for long term positive health so I'm surprised that the persistent failure to adhere to weight management programs was not accepted. It clearly states the word persistent and although weight management is extremely difficult for increasing amounts of adults in the UK it must be a priority in childhood. Perhaps the inclusion of the word obesity in stead of weight management would differentiate between the over weight child and the child who will suffer significant health problems if lifestyle changes not made.	Thank you for your comment. The GDG holds the opposite view about the word obesity. Nonetheless, this statement has been included in a modified form.
SH	NHS Direct	7	Appendices	C2.8	121	Head banging being rejected leaves me concerned at what the professional should consider in this behaviour if medical causes have been rigorously ruled out	The GDG consensus was that there was insufficient evidence to link head-banging with maltreatment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Norfolk Youth offending Team	1	Full	2.1 pages 23/24	46 Health care professionals should consider sexual abuse when a young person aged 13 to 15 years 47 presents with any sexually transmitted infection (such as neisseria gonorrheae, chlamydia trachomatis, 48 syphilis, anoge	My concern, given my job, is what level of skill/training/experience will health workers have in being able to assess whether or not the sexual activity with a peer is truly consensual? Consent is complex – below is our draft for the LSCB (it includes some work done by sexual health workers here as well) - "Consent is based on choice. Consent is active not passive. Consent is only possible when there is equal power. Forcing someone to give in is not consent. Going along with something because of wanting to fit in is not consent….If you can't say 'no' comfortably then 'yes' has no meaning. If you are unwilling to accept 'no' then yes has no meaning." Adams & Fay 1984 - Under the Sexual Offences Act 2003 children under the age of 13 are considered of insufficient age to give consent to sexual activity. For this reason all cases of children under the age of 13 who are believed to be or have been engaged in sexual activity must be referred to Children's Social Services and the	Thank you. We agree that establishing whether sexual activity is consensual is complex. However, the GDG believes it is necessary for the professional to establish this. How to do so falls outside the scope of this guidance. The recommendations that the GDG have made where it is necessary to establish whether sexual activity has been consensual are all 'consider' recommendations. This means that health professionals are alerted to the need to seek advice from experienced peers who would be able to help establish whether sexual activity was consensual.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					nital warts, genital herpes simplex, hepatitis B and C, HIV and trichomonas vaginalis) 49 unless there is clear evidence of blood contamination or that the STI was acquired from consensual 50 sexual activity with a peer.	Police. Consent is when **one person gives their permission to another person** to do something, knowing fully what "yes" to that means, and what could happen afterwards. Either of you must also **be able at all times to say "no"** and have that "no" accepted. **Drugs** and **alcohol** can affect people's ability to make decisions, including whether or not they want to be sexual with someone else. This means that if someone is clearly showing the effects of drugs or alcohol use **they cannot give consent.** Being with them in a sexual way when they don't know what's going on is the same as rape. Further investigation needs to take place in all cases where one of the sexual partners is known to any agency as having other concerning sexual relationships	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Power Imbalances Sexual abuse and exploitation of a child or young person involves an imbalance of power this means consent is not given. Any assessment should seek to identify possible power imbalances within a relationship. These can result from differences in size, age, material wealth and/or psychological, social and physical development. In addition gender, sexuality, race and levels of sexual knowledge can be used to exert power. Whilst a large age differential could be a key indicator e.g. a 15-year-old girl and a 20-year-old man, practitioners should be aware that a 14 or 15 year old boy, supported by a group of his peers, is able to exert very real pressure over a girl of the same age or older. There will also be instances when the sexual predator is a woman or girl and the victim is a boy. Both children/young people need to understand what they are agreeing too before saying yes and compliance or co-operation is not the same as informed consent. Both also need to know what behaviour is appropriate and be aware of the consequences of engaging in that behaviour. For the agreement to be	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						consenting it must be possible to change your mind and say no at any point. Where a power imbalance results in coercion, manipulation, threats and/or bribery and seduction, these pressures can be applied to a young person by one or two individuals, or through peer pressure (i.e. group bullying). Professionals assessing the nature of a child or young person's relationship need to be aware of the possibility that either or both of these situations can exist for the child or a young person – and conduct an holistic assessment of the young person's needs. There will be an imbalance of power and the child or young person will not be deemed able to give consent if the sexual partner is in a position of trust or is a family member as defined by the Sexual Offences Act 2003; and/or any pre-existing legislation It must be noted that the above list is not comprehensive, and each Situation/context must be assessed on an individual basis. END	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Many adults mistake co-operation or compliance as consent, which it is not, and some young people do not view their relationships as abusive but this does not mean that they are always correct. I am not suggesting criminalizing young people but am anxious that a proper robust assessment is undertaken not just the acceptance of young person saying they consented.	
SH	North Staffs PCT	1	Full	3.1	32	Line 32. intra-family violence or history of violent offending. Add "and violence towards animals"	Thank you for raising this. We have added animal abuse to the list of risk factors in this section.
SH	North Tyneside PCT	1	NICE	general	Page3	The guidance gives the impression that it is to raise awareness in health professionals who are not specialist in child protection,to suspect maltreatment as a possibility. does this imply that the guidance is implicitly for primary health care professionals and junior doctors working in accident and emergency??	Thank you for raising this issue. The scope for the guideline states that a specialist is a named or designated professional or a professional who is recognised to be a specialist in the field of maltreatment, and this is not related to seniority or sector.
SH	North Tyneside PCT	2	NICE	1.1.2	Page7	In considering the possibility of maltreatment,ie the clinician has this as a possible differential diagnosis, the third line then lacks clarity as it says, looking into records might now make the health professional suspect maltreatment. it is understood that the clinician was already suspecting maltreatment and looking for evidence to strengthen the suspicion,not to suspect it in the first place after looking through notes	Thank you for your comment. The definition of 'consider' has been changed to provide the health professional with 3 options. Firstly, they may move their "consideration" into a "suspicion" after gathering collateral information, or they may decide that there is no reason to even consider maltreatment, or they may continue to consider maltreatment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	North Tyneside PCT	3	NICE	1.1.2	Page7	Looking through notes A mention of looking through not only the child's records,but also records of parents and siblings,might be a useful guidance. this will highlight the increased risk children coming from families with" hidden harm" face.and the importance of looking in the parental records when available.	Thank you for your comment. These questions of 'hidden harm' are outside the scope of the guidance.
SH	North Tyneside PCT	4	NICE	1.1.2	Page8	Gathering collateral information we would expect health professionals to refer without further discussion review the child at a later date, this needs clarity if there is suspicion of maltreatment it is safer to refer than to review the child at a later date.this is only safe guidance if the clinician is not clear about the diagnosis	Thank you for your comment. The GDG has taken a cautious approach to suspicion of maltreatment. If an indicator falls into the 'suspect' category, a referral is made. If it falls into the 'consider' category, there may be a plausible explanation for the indicator that is not maltreatment. The 'consider' category aims to reduce the number of false-positive referrals.
SH	North Tyneside PCT	5	NICE	1.2.9	Page9	Instead of referring to definitions in working together the document can refer back to page4/5 for its own definitions and the "hidden harm" areas,like Exposure to domestic abuse in the family Exposure to drug abuse in the family Mental health problems in parents Prostitution And drug trafficking Could be added to the forms of abuse on page4/5 of the consultation document	Thank you for your comment. This recommendation has been removed. Readers are now referred to supplementary guidance in Working Together. These 'hidden harms' are outside the scope of this guidance so we cannot make recommendations about them.
SH	North Tyneside PCT	6	NICE	1.3.2	Page10	Is it too strong to say" any bruising in babies and children who are not independently mobile"?? A child 10mnths old,though not independently mobile,is active enough to get some bruising,with reasonable explnantion,as should	Thank you for your comment. This recommendation needs to be read in the context of a bruise in a baby who is not independently mobile and when there is no suitable explanation or absent medical cause etc.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						always be the case.	A child of 10 months who is crawling is independently mobile and as you say is at risk of sustaining a bruise. He or she could crawl to the top of a stairway and fall down for example as a result of being independently mobile.
SH	North Tyneside PCT	7	NICE	1.3.10	Page12	The word "consider2 does not give weight to the importance of strongly suspecting child harm in the presence of an unexplained fracture in a child	Thank you. This section has been reviewed and amended in accordance with several similar suggestions from other stakeholders.
SH	North Tyneside PCT	8	NICE	1.3.12 to1.3.16	Page 13,page14	The areas discussed here are specialist areas,where child abuse is suspected but these findings are found by doctors who are specialist in the field of child protection after initial refrerrals to them. This does not apply to detection by health care professionals who are not specialist in child protection,which was the first premise of the draft.	Thank you for your comment. It is the GDG's opinion that these presentations may be observed by people who are not specialists in child protection and therefore should remain in the guidance.
SH	North Tyneside PCT	9	NICE	1.3.19 and 1.3.20	Page 15	Could be joined as there is repetition of the context in the second denomination	Thank you for your comment. The context is different for these two recommendations so it is not possible to combine them.
SH	North Tyneside PCT	10	NICE	1.3.27 and 1.3.28	Page 16	First mentions age 13 to 15 Second paragraph mentions age 16 to 17 It only considers disparity of power,age and other factors in defining if the sexual relationship is harmful to one party,for the ages 16 to 17. These factors should also be considered in a seemingly consensual relationship of age 13 to 15,to evaluate the sexual relationship,to rule out if it is harmful to one party.	Thank you for your comment. We agree that, by definition, consensual relationships are free of disparity of power.
SH	North Tyneside	11	NICE	1.4.8	Page 18	The non availability of dentist who undertake NHS work in certain areas more than	Thank you for your comment. This recommendation is about ongoing dental

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	PCT					others,might have an impact on getting help for dental hygiene in families with already limited resources	caries for which treatment is not sought; it does not cover general dental hygiene.
SH	North Tyneside PCT	12	NICE	1.4.14	Page19	The phrase abnormal growth patterns imply obesity Is this a proven link to maltreatment,is this too inclusive as obesity in childhood might have other confounding factors,which have not been completely explored by the medical faculty as yet.	Thank you for your comment. This recommendation has been removed.
SH	North Tyneside PCT	13	NICE	1.5.5	Page20	Administration of inappropriate substances This should not affect parents who seek prompt advice after an accidental administration of wrong drug or wrong dose of a prescribed drug to a child	Thank you for highlighting this. We have added the word 'deliberate' to this bullet point to avoid the situation you describe.
SH	North Tyneside PCT	14	NICE	1.5.6	Page 20	Hypernatreamic dehydration is out of scope of this document This is again a diagnosis undertaken by doctors who are specialist in child protection,and is only confirmed after investigations under specialist care	Thank you for your comment. This has been changed to 'hypernatraemia'. This guidance is directed at all healthcare professionals so a hospital paediatrician / laboratory staff could well be the first to identify a very high sodium level.
SH	North Tyneside PCT	15	NICE	1.6.4	Page 23	"care taking role", is a difficult area, We should be registering children who are carers and directing them to appropriate charities for support and highlight the carer role more. But does this caring role constitute child neglect or abuse??	Thank you for your comment. Taking a care-taking role constitutes maltreatment when it interferes with normal developmental tasks.
SH	North Tyneside PCT	16	NICE	1.6.7	Page 24	Abdominal pain in young children is traditionally a grey area ,and has few explanations,even after ruling out an obvious medical cause. Should this be considered in child maltreatment??	Thank you for your comment. The GDG believes that once psychosocial stressors and medical causes have been ruled out, recurrent abdominal pain is a reason to consider maltreatment as a possible cause.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	NSPCC		General			There is no recognition of the social model of disability. The National Working Group on Child Protection and Disability has made a number of recommendations[i] about the involvement of children and the identification of abuse. It is important to remember that with complex disability a child may be seen intimately by a number of people and this can increase the risk of abuse. We have inserted some comments , but recognise the paucity of research in this area does mean the evidence base is not there. We would therefore urge NICE to discuss this issue with relevant groups.	Noted with thanks. The GDG agrees the difficulties surrounding maltreatment in disabled children and suggests that you submit this as a theme for future NICE guidance. (**http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp**)
SH	NSPCC	1	General			It is important for professionals to be able to see a child alone. We are conscious that to do so professionals would have to seek the permission of the parent/carer or other person accompanying the child - refusal of such permission without good reason can itself be instructive. Guidance on this issue is provided in paragraphs 5.4 and 5.39 of HM Government's *Working Together to Safeguard Children* which it would be helpful to reference.	Thank you for your comment. The GDG proposes the following recommendation and hopes that this addresses your concern: 'Consider child maltreatment if a parent or carer refuses to allow a child or young person the opportunity to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.'
SH	NSPCC	2	General			We also would like to see more emphasis on a history direct from the child.	Thank you for your comment. We hope that the following recommendation addresses this concern: 'Seek an explanation for any injury or presentation from both the parent/carer and the child or young person in an open and non-judgemental manner'
SH	NSPCC	3	General			The location of this document within a medical context does limit its value. We would have found it helpful for this to be public health guidance along the lines of the forthcoming	Thank you for your comment which has been noted. Although the guidance has been developed for health professionals, it will be available to all professionals who work with

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						LAC guidance. This is disappointing and we hope that when this document is reviewed it come under the scrutiny of a public health panel with an appropriate balance of clinical and social care expertise.	children.
SH	NSPCC	5	General			Communication - there is no reference to the importance of good communication with the child / young person and parents. This needs to be incorporated as good communication does make a big difference to the identification of the issues, the intervention that is chosen, and the outcome of an intervention.	Thank you for your comment. The information about communication appears in the NICE version of the guideline. Aspects of communication are also addressed within the full version, in chapter 1.
SH	NSPCC	6	General			Confidentiality and information sharing are problematic areas. It would be helpful to make reference to relevant guidance – for England this is HM Government – information sharing guidance for practitioners and managers(and can be found at: http://www.nspcc.org.uk/Inform/publications/Downloads/itdoesnthappentodisabledchildren_wdf48044.pdf .	Thank you for your comment. We have now listed the Information Sharing Pocket Guide in the list of relevant documents.
SH	NSPCC	7	General			Pre –term babies and especially ones born with an addiction create very specific parenting challenges. Issues of attachment are difficult and these need to be assessed carefully with a particular focus on assessing the support needs of the carers.	Thank you for your comment. Indeed this is true, but the assessments and support needs of the carers are outside the scope of this guidance.
SH	NSPCC	8	General			Social factors such as domestic violence and parental mental ill health, need to be borne in mind by health professionals. As a minimum we would expect reference to risk factors associated with parental ill-health to appear in the 'Quick Reference Guidance'	Thank you for raising this. As outlined in chapter 1 of the full guideline, the risk factors that you mention are outside the scope of the guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						and preferably also in the full set of recommendations. We understand that this guidance is specifically about the recognition of maltreatment. Nevertheless, in light of the known links between particular parental/carer conditions and child maltreatment, we are disappointed at the lack of attention given to known risk factors. Recognition of such risk factors is a significant tool in both the recognition as well as the prevention of child abuse and neglect, and we therefore consider that reference to parental risk factors is a significant factor in considering or suspecting child maltreatment, and therefore has a place in this guidance. We understand that the links between parental ill-health and child abuse and neglect may be covered in other NICE Guidance publications, however, clear reinforcement, and detailed cross referencing should appropriately appear in Guidance related to issues of recognition of child maltreatment. We consider where a parent presents with problems including: substance or alcohol abuse; depression; or where violence or domestic violence is known to be a factor in the family/household health professionals should be alerted to the known links to child abuse and neglect and the need to proactively satisfy themselves as to the emotional and	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						physical health and well-being of children and young people.	
SH	NSPCC	9	General			Both the Full document and NICE summary provide a lot of helpful material but we are concerned that their length is likely to lead to a number of practitioners disregarding them.	Thank you for your comment. We have been working with the editorial team at NICE to establish a format for this guidance that is usable by its intended audience.
SH	NSPCC	10	General			The documents are important and it would be helpful for any dissemination strategy to recognise that the documents will be of relevance to a number of different professionals, such as social workers and policemen not only health professionals.	Thank you for suggesting this. We are passing your comment to the implementation team at NICE whose responsibility it is to disseminate the guidance to health professionals in the NHS.
SH	NSPCC	11	General			The drawing together of evidence will highlight for many practitioners the need to revisit their knowledge. Has any thought been given to how the appropriate NHS bodies will be able to provide the necessary training on the diagnosis of child maltreatment ?	Thank you for your comments. Education and training for healthcare professionals are outside the scope of this guidance but we will pass your concerns on to the implementation team at NICE.
SH	NSPCC	12	General			The research that is cited focuses primarily on medical evidence. We are concerned that social risk factors are beyond the scope of the document. Information from studies such as Brandon et al on the Biennial Review of Child Deaths and Serious Case reviews 2003-05 can provide other important sources which can inform the prevention, identification, and treatment of child maltreatment.	Thank you for raising this. Risk factors are a specific exclusion from the scope of the guideline.
SH	NSPCC	13	General			We do believe there are gaps in the evidence as the focus appears to be very medical with little recognition of the social issues that do lead to maltreatment. We would urge NICE to consider reviewing evidence from sources such as Social Care Institute of Excellence.	Thank you for your comment. As stated above, this is outside the scope of the guidance but we will pass your concern on to NICE.
SH	NSPCC	14	General			**We understand that the guidance is for**	Thank you for this detailed response.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						England only. However as NICE guidance does extend to Northern Ireland and Wales. We would recommend that with minor policy amendments it could be applied there. We have set out what might need to be inserted for NI as an example NICE guidance also extends to Northern Ireland but it should be remembered that Northern Ireland has its own body and law and guidance. The Department of Health and Social Services and Public Safety (DHSSPS) is the broad equivalent of the Department of Health in England and leads on child protection policy for the Health and Social Care Service in Northern Ireland. The Children (NI) Order 1995 is the key legislative source for child protection supplemented by guidance contained in *Cooperating to Safeguard Children 2003(DHSSPS)* which contains identical definitions of harm to *Working Together*. References to *Working Together* should be taken to read Co-operating to Safeguard Children for the purposes of this guidance in Northern Ireland. Co-operating to Safeguard Children is further augmented by detailed guidance in the *Area Child Protection Committees' Regional Policies and Procedures.* The *Sexual Offences (NI) Order 2008* enabled on 2nd February 2009 brings Northern Ireland into line with England and Wales on age of consent (16 formerly 17) and offences to children under 13 and under 16 as set out in the Sexual Offences Act 2003 .	According to guidance from DHSSPS, the decision on whether to disseminate NICE guidance rests with them. The GDG will not make specific reference to statutory documents relating to Northern Ireland. The process by which DHSSPS makes its decision would enable an effective translation of this document to suit local legislation.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						We would be happy to provide more advice if that would be helpful.	
SH	NSPCC	15	NICE		Pg 3	It would be helpful to have a sentence reinforcing the point that it is every health professional's responsibility to consider whether maltreatment is an issue when they are assessing a child.	Thank you for this suggestion. We agree with your point and will be including it.
SH	NSPCC	16	NICE		Pg 6	It is good that reference is made to the need for communication to take into account additional needs such as physical, sensory or learning disabilities or inability to speak or read English. However, if the healthcare professional has little knowledge or experience of working with deaf and disabled children they may not be aware of the extent of which this could involve. We think it would be useful to spell out more specifically the sorts of things that this might involve. This could possible be done through the use of examples. These could include such things as the child's level of conceptual understanding, how to convey key information most effectively, possible areas of misunderstanding, the child's preferred method of communication, any communication equipment that may be required, need for BSL interpreting support, use of images/pictures, illustrations for conveying information, information being available in easy read, audio or BSL on video. There should also be a statement making it clear that the healthcare professional should ensure they have sought the advice of the children/young person and/ or the parent/carer	Thank you for your comment. This is outside the scope of the guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						about their preferred means of communication. There is a separate issue about communicating effectively with the parent or carer of any child where the parent or carer is deaf or disabled or may not speak English as their first language. Healthcare professionals should ensure effective communication in order to ascertain full information about the child and to enable the parent/carer and family to support the child. For deaf and disabled adults this may include information in Easy Read or audio and in BSL and may require, BSL interpreter, communication support.	
SH	NSPCC	17	NICE	1.2.3	9	It is important to include the point that healthcare professionals should speak to parents.	Thank you for this suggestion. Unfortunately, communication with parents/carers about suspicions is outside the scope of this guidance.
SH	NSPCC	18	NICE	1.2.4	9	More is needed to explain this. No culture should condone abuse and it should be clear that every child has a right to protection from abuse under the UN Convention on the Rights of the Child, regardless of their culture, ethnicity, ability and religion. It should be clear that a culturally relativist approach to abuse is not acceptable.	Thank you for your comment. This statement has been amended to ensure clarity.
SH	NSPCC	19	NICE	1.2.6	9	This needs to be expanded in terms of recognising barriers around communication as well as the potential for misdiagnosis. There are many barriers to recognition of abuse for deaf and disabled children. This might include: assumptions that possible indicators of abuse such mood, behaviour or injuries are assumed to have been the result of a child's disability or	Thank you. This is covered in the text about communication in the NICE version.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						deafness; assumptions or lack of awareness of the impact of certain actions upon the child, a tendency to rely too much on the parents account of what may have happened or to apply lower standards where a parent or carer may be trying their best to cope under difficult circumstances, especially if there is difficulty communicating directly with the child.	
SH	NSPCC	20	NICE	1.2.9	9	Our understanding is that NICE guidelines are also used in Wales and N Ireland and therefore it would be helpful if the relevant guidance for each devolved nation were referenced as well.	Thank you for your comment. This recommendation has been removed so there is no longer need to refer to the Welsh guidance here.
SH	NSPCC	21	NICE	1.3.3	10	We would recommend referencing a pamphlet based on a systematic review by Cardiff university and published by the NSPCC on bites.[ii]	Thank you for your comment. The Cardiff work has been taken into consideration as part of the evidence base that supports the recommendations. NICE's editorial policy does not permit us to cite external documents in recommendations.
SH	NSPCC	22	NICE	1.4.5	18	Could also include here lack of stimulation, lack of play opportunities, excluding the child from family activities because they are deaf or disabled. Also where staff become aware that a parent or carer is either not able to communicate with the child or does not appear to be committed to this. Examples include a lack of commitment to learn the child method's method of communication e.g. BSL, Makaton, unfamiliarity with child's communication equipment, or failure to use this	Thank you for this suggestion. This point is covered in the recommendations about emotional abuse under "failure to promote the child's appropriate socialisation, for example by involving children in unlawful activities, by isolation and by not providing stimulation or education"
SH	NSPCC	23	NICE	1.4.7	18	Suggest adding the word treatment so it is medication and/or treatment. Treatment should be in the manner prescribed	Thank you for this suggestion. This change has been made.
SH	NSPCC	24	NICE	1.6.2	Pg 23	Caution is needed here in that the possible	Thank you for raising this. This issue is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						indicators of abuse are not assumed inappropriately to be the result of deafness or disability.	covered in the introductory chapter where we state 'The indicators of maltreatment in children with disabilities may also be features of the disability thus making identification of maltreatment more difficult.'
SH	NSPCC	25	NICE	1.6.6	Pg 24	Could add: or knowingly placing themselves in unsafe situations	Thank you for your comment. his has been considered by the GDG. It represents risk of harm, not harm itself and as such has not been included in this section.
SH	NSPCC	26	Full	2.1	Pg 23 Line 41	The issue of the age of the child / young person is addressed but then no further guidance is provided about the complexities of determining possible abuse even when the behaviour may apparently have been consensual. If the reader needs to refer to this guidance then they will be very likely not to have a sufficient understanding of these issues and require further training – see also our comments above 11) in relation to training.	Thank you. We agree that establishing whether sexual activity is consensual is complex. However, the GDG believes it is necessary for the professional to establish this. How to do so falls outside the scope of this guidance.
SH	NSPCC	27	Full	2.1	Pg24 Line 10	The issue of the age of the child / young person is addressed but then no further guidance is provided about the complexities of determining possible abuse even when the behaviour may apparently have been consensual. If the reader needs to refer to this guidance then they will be very likely not to have a sufficient understanding of these issues and require further training – see also our comments above (11) in relation to training.	Thank you. We agree that establishing whether sexual activity is consensual is complex. However, the GDG believes it is necessary for the professional to establish this. How to do this falls outside the scope of this guidance.
SH	NSPCC	28	Full	2.4	31	In the flowchart the use of the word 'mean' is unclear; it may be simpler to put the definition in the box for 'consider' or 'suspect'.	Thank you for your comment. This editorial point has been addressed.
SH	NSPCC	29	Full	2.4	31	This needs to include information about when you talk to a parent.	Thank you for this suggestion. Unfortunately, communication with parents/carers about

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							suspicions is outside the scope of this guidance.
SH	NSPCC	30	Full	2.4	31	There should be some explicit action around when a child's case (?) should be reviewed.	Thank you for this suggestion. We have changed the wording to read "ensure review of the child or young person at a *date appropriate to the concern*, looking out for repeated presentations of this or any other alerting feature." We feel that we cannot be more prescriptive than this because the length of time depends on a number of factors. We hope this change is helpful, however.
SH	NSPCC	31	Full	2.4	31	Does the flowchart tie in with local guidance?	Thank you for your comment. The flowchart represents the guideline development group's definitions of 'consider' and 'suspect' and their associated actions within the context of this guidance.
SH	NSPCC	32	Full	3.1	Pg 33 line 8	Insert "The disability itself may be an indicator of child maltreatment e.g. incest, certain rare disabilities". Our evidence for this is the Serious Case Review on the H family and the recent Sheffield case.	Thank you for your comment. This is beyond the scope of the guidance.
SH	NSPCC	33	Full	3.1.	Pg 33 line 34	We would suggest saying: 'it should lead to safety of the child being established either way, or risk analysed'.	Thank you for this suggestion.
SH	NSPCC	34	Full	3.1	Pg 33 line 47	We suggest inserting 'record the child / young person's view (if appropriate)'	Thank you for your comment. We hope that the following recommendation addresses this concern: 'Seek an explanation for any injury or presentation from both the parent/carer and the child or young person in an open and non-judgemental manner'
SH	NSPCC	35	Full	3.1	Pg 34 Line 6-15	This should include a check to see if a Child Protection plan is in place. Health professionals needs to be aware of ContactPoint and how and when to access it in	Thank you for this suggestion. Prior to consultation, the GDG had considered ContactPoint as a resource for inclusion. As this facility has not been rolled out yet, the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						order to check which, if any, other agencies the child is known to, and if the child has a CPP".	GDG is unable to recommend it as a reference point. We will, however, pass your suggestion on to the implementation team at NICE who will hopefully take it forward at a later date.
SH	NSPCC	36	Full	3.1	Pg 34 Line 8	We would insert "record CYP view"	Thank you for your comment. We hope that the following recommendation addresses this concern: 'Seek an explanation for any injury or presentation from both the parent/carer and the child or young person in an open and non-judgemental manner'
SH	NSPCC	37	Full	3.1	Pg 34 Line 30-31	This should include a check to see if a Child Protection plan is in place. Health professionals needs to be aware of ContactPoint and how and when to access it in order to check which, if any, other agencies the child is known to, and if the child has a CPP".	Thank you for this suggestion. Prior to consultation, the GDG had considered ContactPoint as a resource for inclusion. As this facility has not been rolled out yet, the GDG is unable to recommend it as a reference point. We will, however, pass your suggestion on to the implementation team at NICE who will hopefully take it forward at a later date.
SH	NSPCC	38	Full	4.14	Pg 40 line 43	There are occasions when children have bizarre burns such as being branded by an iron or other implement. We suggest it would be helpful to reference our leaflet on burns and scalds	Thank you for this suggestion. The evidence base that supports the NSPCC Core-info leaflet is the same as that used to derive recommendations for this document.
SH	NSPCC	39	Full	4.1.6	42	The section on hair loss is unclear, as one needs to consider the cause: is the child doing this, or an adult?	Thank you. This recommendation has been removed and inflicted hair-pulling is covered by a general recommendation on unusual injuries. Self-inflicted hair-pulling is referred to later under 'self harm'.
SH	NSPCC	40	Full	4.1.9	49 Line 11	Is shaken baby syndrome the right terminology? Non accidental head injury or inflicted brain injury is the terminology used by the NSPCC. It would be helpful to refer to the NSPCC *CoreInfo leaflet: Non accidental head and spinal injuries.*	Thank you for this suggestion. "Shaken baby syndrome" has been changed to "abusive head trauma" The evidence base that supports the NSPCC Core-info leaflet is the same as that used to derive recommendations for this document.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	NSPCC	41	Full	4.1.1	37	It would be helpful to refer to the NSPCC *Core-info leaflet: bruises on children*, which highlights the findings from the systematic review on bruises i.e. that the evidence suggests that it is not possible to age a bruise from an assessment of colour.	Thank you for this suggestion. The evidence base that supports the NSPCC Core-info leaflet is the same as that used to derive recommendations for this document.
SH	NSPCC	42	Full	4.1.9	50 Line 1	This should include a recommendation that there should be a consultation with a paediatric ophthalmologist.	Thank you for your comment. Recommendations about what to do once child maltreatment is suspected are outside the scope of the guidance, as are care pathways for the clinical presentations discussed.
SH	NSPCC	43	Full	4.1.9		It would be hepful to refer to the NSPCC *Core-info leaflet: Non-accidental head and spinal injuries*	Thank you for this suggestion. The evidence base that supports the NSPCC Core-info leaflet is the same as that used to derive recommendations for this document.
SH	NSPCC	44	Full	4.2.3	Pg 61 Line 29-33	We would insert the phrase for 'clear evidence' before 'that the STI was acquired from consensual activity with a peer'.as there is lots of consideration for the next age group but not for this one(13-15). Some LSCBS have supported the development of questionnaires to be used by health professionals to make this assessment. Young women at risk of sexual exploitation may appear to be in a consensual relationship to health professionals, more detailed scrutiny by health professionals might elicit something different.	Thank you. This change has been made.
SH	NSPCC	45	Full	7.2.8	Pg 101 line 41	This should also include a reference to a household pet.	Thank you for this suggestion. We have provided a list that is not exhaustive, so your point is implicit in our recommendation.
SH	NSPCC	46	Full	2.1	Pg 21	It would be useful to set out a definition for maltreatment drawn from HM Government	Thank you for your comment. Chapter 2 presents all of the recommended actions for

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						guidance *Working Together to Safeguard Children.*	healthcare professionals. The definitions of maltreatment as per the English version of Working Together are listed later in this document.
SH	NSPCC	47	Full	7.1	Pg 85 Line 2	Language such as emotional dysregulation is not commonly used by all health professionals and so it would be helpful for a more common term to be used–	Thank you for your response. This term has been added to the glossary.
SH	NSPCC	48	Full	7.2.7	Pg 98 Line 18	It would be more helpful to say "should suspect emotional neglect…" instead of ""should consider emotional neglect….".	Thank you for your comment. Both the GDG and the Delphi panel agreed that this should be 'consider'.
SH	NSPCC	49	Full	7.2.7	Pg 99 Line 45	Substitute " suspect" for " consider".	Thank you for this suggestion. In line with emotional abuse recommendation 1.7.1, the GDG agrees that this should be changed to 'suspect'.
SH	NSPCC	50	Full	8	Pg 107 Line 18	Substitute " suspect" for " consider".	Thank you for this suggestion. The GDG has now revised the recommendations in this section to read: "consider emotional abuse when there is concern that parent-child interactions may be harmful…." "suspect emotional abuse when persistent harmful parent-child interactions are observed or reported…"
SH	NSPCC	51	Full	8	Pg 107 Line 29	Substitute " suspect" for " consider".	Thank you for this suggestion. There are now two recommendations here: consider emotional neglect when there is emotional unavailability and unresponsiveness from the parent/carer towards the child … and suspect emotional neglect when there is persistent emotional unavailability and unresponsiveness from the parent/carer

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							towards the child.
SH	NSPCC	52	NICE	General		**Some specific comments in relation to children who are deaf and/ or disabled.** **Some of our staff dealing with disability have flagged up the following based on their knowledge and experience. The comments relate to the NICE guidance:**	Thank you for your comments on this important matter. These have been addressed below.
SH	NSPCC	53	NICE	1.6.3		1.6.3 Another example to be abuse through communication starvation of a deaf child. The frustration could lead to such responses. It is important they are recognised as resulting from the abuse through communication starvation and not the result of deafness.	Thank you for your comment. This is covered under 'Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent/carer towards the child, particularly infants.'
SH	NSPCC	54	NICE	1.6.4		1.6.4 Could include an additional point that it is abusive to repeatedly put a hearing child who can sign into positions where they interpret for their parents or carers. Neither families, healthcare professionals nor others should be doing this	Thank you. This is covered under 'adopting a care-taking role for parents/carers or siblings'.
SH	NSPCC	55	NICE	1.7.1		1.7.1 Suggest add a further bullet point: Inability to communicate effectively with the child and apparent lack of commitment to try and do this (e.g. learning BSL, Makaton, lack of familiarity of the child's methods of communication and failure to use of the child's communication equipment)	Thank you for your comment. This is covered under 'failure to promote the child's appropriate socialisation' and 'developmentally inappropriate expectations of or interactions with a child'.
SH	Public Health Research Group	1	FULL	general	general	The document is entirely authoritarian in its approach. There is no mention whatsoever of children's rights to be consulted about the	Thank you for commenting on this draft. We do not agree that the guideline is authoritarian and the approach of the GDG in forming this

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						interventions that are ostensibly taken on their behalf. There is no mention of the circumstances in which the practitioner should seek the child's consent and of the weight that needs to be placed on the wishes and feelings of the child.	guidance is to place the child at the centre of the practitioner's thinking. Please note that the guidance does not recommend interventions and therefore the GDG believes that the question of seeking consent for procedures and addressing preferences does not arise. However, a related issue which does arise is that of consent about information sharing. This has been addressed in the actions associated with considering maltreatment and reads: "gather collateral information from other disciplines within health and other agencies, having used professional judgement about whether to explain to the child, young person and/or parent/carer your need to gather this information because of the need for an overall assessment of the child".
SH	Public Health Research Group	2	FULL	general	general	Child abuse is a verdict and not a diagnosis. Only a court can legally make this determination. The usurpation of the role of the court has been criticised in several high ranking legal judgements. Prior to the court case, the viewpoint of practitioners can only be partial. The document should warn practitioners against usurping the role of the judge and jury, so as not to prejudice the legal process.	Thank you for your comment. This guidance is about considering or suspecting child maltreatment; it is not about proving maltreatment and the GDG believes this to be clear in the document.
SH	Public Health Research Group	3	FULL	general	general	The conceptualisation of unexplained injury or illness as child abuse places the burden of proof on the accused and constitutes a reversal of the burden of proof that falls on the prosecution in English- speaking countries. It is precisely this reversal that has produced serious Miscarriages of Justice.	Thank you for your comment. The detailed assessments you refer to are outside the scope of the guidance. The guidance is aimed at informing initial critical thinking by health care professionals to support all children and their carers. It does not address diagnosis.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Children whose illnesses or injuries are not well understood by their practitioners, children who may be viewed as placing a financial burden on those who seek to evade financial liability, children who evidence rare conditions sought by researchers, children whose conditions are politically unnameable and children who have been treated negligently or abusively by professionals are at serious risk of being deprived of appropriate medical, social and educational care as a result of false counter-allegations of child abuse. The guideline does nothing to protect these children and secure appropriate treatment to meet their needs. Indeed, the problems of professional misconduct and iatrogenic abuse are conspicuously absent from the guideline.	
SH	Public Health Research Group	4	FULL	general	general	Practitioners need to be forewarned against using 'techniques of neutralisation' that minimise awareness of the harmful effects of both false positive and false negative Child Protection errors.	Thank you for your comment. The process of consider and suspect has been clearly set out in the final guidance and places the child at the centre of the assessment process so that the child's needs are prioritised and thoroughly assessed
SH	Public Health Research Group	5	FULL	general	general	The document expresses a complete lack of awareness of the harm caused to children, when their conditions are misinterpreted as child abuse. Practitioners need to be apprised of the harmful impacts of false allegations. This harm includes children not receiving appropriate treatment, on occasion resulting in death and psychological damage from trauma, separation and the investigative techniques.	Thank you for your comment. The GDG adopted a cautious approach to suspecting maltreatment. In addition we recognise that indications may have innocent causes that should also be considered when professionals assess a child. False allegations are outside the remit of the guideline and we would hope professional training programmes would address your concern.
SH	Public Health	6	FULL	general	Gener	Practitioners need to be warned to maintain an	Thank you for your comment. The GDG

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Research Group				al	open mind while the entirety of the differential diagnosis is explored. Otherwise, important tests may be missed. It is problematical that practitioners may not be aware of the necessary tests that may act in an inculpatory and exculpatory manner. This lack of awareness results in delay and extended harm to children.	agrees with this comment. 'Open-mindedness' is implied in the actions associated with 'considering' maltreatment.
SH	Public Health Research Group	7	FULL	general	general	The word 'disclosure' in relation to sexual abuse should be replaced with the less biased term, 'allegation'.	Thank you for your comment. The GDG believes that 'disclosure' is less biased than allegation. Disclosure is used here in the sense of revealing something that hitherto had not been revealed.
SH	Public Health Research Group	8	FULL	general	general	Emergency and non-emergency situations need to be differentiated so that appropriate procedures can be developed for each	Thank you for your comment. It is not clear whether you refer to medical emergencies or child protection emergencies. Nonetheless, whether an indicator causes a health professional to consider or suspect maltreatment is a clue to the urgency of the situation.
SH	Public Health Research Group	9	FULL		4	Lines 4-22 The constitution of the Guideline Development Group is not remotely representative of a broad spectrum of stakeholders.	Thank you for this comment. In addition to the GDG, the Delphi group supported the development of the guideline and included a wide range of professionals.
SH	Public Health Research Group	10	FULL	1.1	14	Lines 16-24 Balance would require that along with noting the harmful effects of child abuse, there is also some mention of the factors that mitigate against these effects and also of the harmful effects of inappropriate Child Protection interventions upon children and their families.	Thank you for your comment.. The purpose of reminding practitioners of the harmful effects of child maltreatment is to encourage them to recognise it when it presents before them. A discussion about other factors affecting outcome for the child is outside the remit of this guideline.
SH	Public Health Research Group	11	FULL	1.7	18	Lines 18-32 The constitution of the Delphi group is very far from representative of the stakeholders.	Thank you for your comment. The Delphi group was formed from potential users of the guidance as identified in 'For whom this

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							guidance is intended'. The stakeholder group is broader than the intended audience.
SH	Public Health Research Group	12	FULL	2.1	20	Line 17 is wholly biased, in assuming that because a practitioner considers abuse, that he or she has a concern.	Thank you for your comment. In terms of our operational definition of 'consider', considering maltreatment means that there is some level of concern about maltreatment. This concern may subside once further information is collected.
SH	Public Health Research Group	13	FULL	2.1	20	Line 43 – 'cultural practices harmful to children…' The potential for cultural disagreement about this needs to be acknowledged.	Thank you. This section has been amended to ensure clarity.
SH	Public Health Research Group	14	FULL	2.1	20	By what process, is a consideration of abuse, properly upgraded to a suspicion of abuse? The slippage from one to the other, without proper procedure is deeply troubling. Indeed, it is important that a sleep-walking from one to the other is warned against. Practitioners are often under-informed about the necessary tests that should be undertaken to ensure that an accurate diagnosis is obtained. Furthermore, parents who seek tests in an attempt to obtain an accurate diagnosis are at risk of a wrongful allegation of MSbP/FII. Practitioners need to be reminded to build an informed differential diagnosis and to seek advice on all the necessary tests, maintaining an open mind throughout.	Thank you for your comment. The clinical indicators and their categorisation into 'consider' and 'suspect' should suffice to lead the health professional. Open-mindedness and building differential diagnoses are implied in the actions associated with 'considering' maltreatment.
SH	Public Health Research Group	15	FULL	2.1	21	Line 1 "act appropriately" – what does this mean? There are different options for "appropriate actions" based on professional judgements.	Thank you for your comment. We agree. This has been amended to ensure clarity.
SH	Public Health Research	16	FULL	2.1	21	After line 8 this section should include an equivalent warning about the risks of	Thank you for your comment. Diagnosis however is not within the scope of the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Group					erroneous over-diagnosis of maltreatment. Apart from wasting valuable resources, children may be harmed when they fail to receive correct treatment because their conditions have been misdiagnosed as abuse. The investigative process itself, is often harmful to children.	guidance.
SH	Public Health Research Group	17	FULL	2.1	25	Lines 1–3: There should be a comment about the importance of distinguishing between neglect and dire poverty.	Thank you for your comment. This is mentioned in the background to the recommendations.
SH	Public Health Research Group	18	FULL	2.1	25	LINE 10: This line is begging the question about what constitutes "an unusual pattern of presentation to, and contact with, healthcare providers."	Thank you for raising this. The term 'unusual' will be subject to the health professional's clinical experience.
SH	Public Health Research Group	19	FULL	2.1	25	Over- and under-nutrition This will give open sesame to those whose vested economic interests are in conflict with the best interests of children, in what is a common problem, and one which is very much social class related. We welcomed a statement from the Royal College of Paediatrics and Child Health that childhood obesity was a public health problem, not a child protection problem. We have already seen one or two seriously damaging cases in this area. Taking children from their parents and putting them on a diet in foster care (no sweeties, cola and crisps, like you had at home with Mum and Dad!) will have disastrous long term social, educational and psychological effects on children. So will implicit threats "unless your kids lose wait we will take them away." This is utterly the wrong	**T**hank you for your comment. This recommendation has been removed.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						approach. In our experience once the professionals know they have the power to use force in one area, there are always some - too many - who over use it. When they can use persuasion, education and support, they work much harder at doing it better, and in a way which is more acceptable to the receiver. Similarly failure to thrive can be due to a diversity of conditions and is easily misdiagnosed as abuse.	
SH	Public Health Research Group	20	FULL	2.1	25	Lines 43–47: This is one of a number of occasions in the whole report where a "controversial history" **alert** is needed (the same is so for the section of Sexual Abuse signs and symptoms. The NICE document as a whole should be more pro-active in drawing attention to specific areas that have been subject to diagnostic controversy, misdiagnoses, miscarriages of justice and disproportionate child protection interventions. MSbP has been critiqued in the literature on a number of fronts, but judging from the text and references, this critique does not seem to have featured in the consideration of the GDG. Problems with the all-embracing, vague and contradictory criteria for MSbP have been documented by a range of authors including mathematicians, psychologists, social workers, lawyers, philosophers, paediatricians and psychiatrists. These definitional confusions have led to the wastage of resources, to the detriment of investigations into other more securely founded forms of abuse. MSbP/FII	Thank you for your comments. The RCPCH, DCSF and DH all support the existence of fabricated or induced illness. You have made reference to grey literature, which was specifically excluded from this review process.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						has been rejected in courts in the UK and abroad as failing to meet evidential standards and there are strong arguments in the literature about the biases in assumptions and procedures used to investigate such allegations. There are further problems with the operationalisation of the concept. Misconceptions, discrimination and narrative extravagance have been written into allegations. There are several different definitions of MSbP, sometimes being used in the same case. This leads to confusion, and potentially to miscarriages of justice. Because of the lack of clarity and precision in MSbP criteria it is possible to construct an argument that abuse has occurred when there is little or no evidence or actual harm. The group needs to consider the inherent problems within the concept of MSbP/FII and clearly delineate how these are to be addressed, rather than simply assuming the reliability and validity of the concept. Otherwise the danger is that the guidelines will be discredited by being linked to future miscarriages of justice.	
SH	Public Health Research Group	21	FULL	2.1	26	Lines 1-15 These wildly inaccurate criteria of abuse are detouring investigative resources away from cases that genuinely warrant investigation. Some diagnoses and tests have become almost emblematic of the distortions and distractions that have blighted Child Protection. Munchausen Syndrome by Proxy/Fabricated or Induced Illness (MSbP/FII) has attained a particular status as a grab bag of myths, mystifications and superstitions. This	Thank you for your comments. The RCPCH, DCSF and DH all support the existence of fabricated or induced illness.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						diagnosis is particularly available for mis-use because it's markers fall within the broad range of normalacy. Almost anyone could be conceptualized as falling within the diagnostic criteria. MSbP/FII is believed to be associated with large scale miscarriages of justice because the allegation is located in narrative spin and requires no actual evidence of abuse. It joins the long line of discredited approaches to Child Protection, though it's ambit may be greater than all the other categories of misdiagnosis.	
SH	Public Health Research Group	22	FULL	2.1	26	Lines 20-42 These distressed emotional states in children may be caused by the Child Protection process and then retrospectively attributed to parental abuse. Once an investigation is underway, it may be difficult to disentangle the effects of the investigation from pre-existing conditions. Health care officials are subjected to contextual pressures that make it virtually impossible to admit to iatrogenic abuse and as a result, abuse by parents becomes a diagnosis by exclusion.	Thank you for your comment. While it is recognised that this may be the case for children well into the investigation process, this document is aimed at front-line health care professionals who may be seeing the child for the first time in some cases. We also hope that should a health professional who has seen any child regularly note any obvious change in the child's behaviour or demeanour then they will also refer to this guideline. This guideline is a tool for health professionals to assist in their choices once observations have been made. It is hoped that the guideline will be used before any investigation is underway.
SH	Public Health Research Group	23	FULL	2.1	27	Lines 40-46 Suspecting maltreatment because a young child masturbates is wholly inappropriate. It is precisely the sort of over-moralising that has earned Child Protection its current reputation for fanaticism. Subjecting children to Child Protection investigations, because they masturbate, and for other inappropriate reasons is highly harmful in its	Thank you for your comment. The GDG has removed the word 'masturbation' from its list of examples. Please note that the listed behaviours are qualified as 'repeated or coercive'.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						consequences for children.	
SH	Public Health Research Group	24	FULL	2.2	29	Lines 3–4 There is an important issue relating to fractures that is not discussed in this document: that is the issue of babies/infants' pain thresholds regarding fractures. In care proceedings findings are often made against parents that they did not seek medical attention when the nature of the infant's fracture(s) would have meant that any reasonable parent would have known that the infant was in severe pain. There is very little existing research about baby/infant responses to pain from fractures. Notwithstanding methodological/ethical challenges, this is an area that requires urgent research.	Thank you for your comment. This is indeed a relevant factor behind fracture identification. It is outside the scope of the review that deals with the indicators that might raise suspicion of abuse which, for in the case of the guidance, would be the fracture itself.
SH	Public Health Research Group	25	FULL	3.1	32	Lines 8–21: This section needs an additional point that provides an **alert** in relation to the tendency of some medical professions to "see abuse everywhere" i.e. emotional/cognitive biases that result in erroneous allegations of abuse.	Thank you for raising this. The GDG does not consider this to be a barrier to recognising maltreatment.
SH	Public Health Research Group	26	FULL	4.1.1	37	Lines 24 and 27 are highly under-informed about the numerous, common, innocent causes of bruising. These recommendations are likely to produce numerous inappropriate investigations, wasting resources and causing serious trauma to children and families.	Thank you for your comment. The GDG believes that innocent causes of bruises have been accounted for.
SH	Public Health Research Group	27	FULL	4.1.2	38	Lines 26 1b "Healthcare professionals should suspect child maltreatment when there is a report or appearance of a human bite mark on a child, in the absence of an independently witnessed incident of biting by another young child to account for the mark." Siblings and other children are unlikely to wait for a witness	Thank you for your comment. This statement was put to the Delphi panel but was not carried through as a recommendation. It is listed only for information purposes.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						before biting one another. This recommendation is tortured and evokes a deliberate attempt to find fault where non would reasonably be suspected. It is yet another example of parents being presumed 'Guilty,' reversing the burden of proof..	
SH	Public Health Research Group	28	FULL	4.1.3	40	Lines 4 and 5 There is no reasonable foundation for these recommendations, whatsoever.	Thank you. There is indeed little evidence around this subject. This recommendation was drawn up utilising GDG consensus as described in the methodology section and stated in the justification of the recommendation. We have made the lack of evidence more explicit.
SH	Public Health Research Group	29	FULL	4.1.7	43	Lines 16-18 Some mention should be made of the lack of consensus around these 'fractures.'	Thank you but we are unsure what this comment refers to.
SH	Public Health Research Group	30	FULL	5.2	67	Line 17 The recommendation that "Healthcare professionals should consider neglect if parents or carers fail to administer essential prescribed medication for their child." is naively unaware of legitimate reasons that a parent may have for not administering prescribed medication, particularly given adverse influences on practitioners' prescribing patterns. The bias in this recommendation is offensive.	Thank you for your comment. The emphasis here is on the word 'essential'. If a parent decided to withhold, say, antibiotic for pneumonia in a child with cystic fibrosis, the child might die. Such an act could not be regarded as defensible on the basis of a potential adverse side effect such as a rash or diarrhoea.
SH	Public Health Research Group	31	FULL	6.7	77-8	Lines 42-4, Lines 1-11 It should be accounted into the analysis that Rosenberg's data was criticised by Meadow (1990) who recommended that the quantitative data on mortality, morbidity and other outcome measure "be neglected." Meadow S. R. Letters to the editor, Child Abuse and Neglect, Volume	Thank you. You cite grey literature; this is specifically excluded from the guideline.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						14, Issue 2 - pp. 141-297 (1990), pp 289-295.	
SH	Public Health Research Group	32	FULL	6.7	79	This is another example where there needs to be an **alert** drawing attention to specific areas that have been subject to diagnostic controversy, misdiagnoses, miscarriages of justice and disproportionate child protection interventions. The recommendation that FII should be considered if: "the parent insists on a medical condition being investigated, recognised and treated in their child despite contrary clinical assessment and which healthcare professionals find difficult to challenge." is most disquieting. By increasing the power of professionals and disempowering patients and their advocates, this approach has caused serious harm to children in several documented cases. Moreover, the recommendation is irrational. If parental claims are valid, they will be difficult to challenge. If they are invalid, they will be easy to challenge. What possible legitimate reason could there be for challenging claims that are difficult to challenge? Similarly the recommendation that FII should be considered if: "reported symptoms are only observed by the carer" has resulted in documented false positives because babies are ordinarily cared for by one person. Witnesses will normally not be present when babies suffer injuries or other medical symptoms.	Thank you for your comments. They have been noted. The GDG points out that FII is suspected if a child's history, physical or psychological presentations and/or findings of assessments, examinations or investigations yield a perplexing discrepancy to a recognised clinical picture *and* the items you mention apply. As we mention above, the criticisms presented in the literature occur in grey literature which has not been cited in this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						The proposed guidelines on MSbP fail to take into account the significant and fundamental criticisms to be found in the literature. Problems have been evidenced in the conceptualisation of MSbP, its empirical base, its statistics and its operationalisation. This well-documented criticism of MSbP/FII comes from mathematicians, psychologists, social workers, lawyers, philosophers, paediatricians and psychiatrists. These problems have resulted in numerous false accusations of MSbP and while the rate of false positives is unknown the inherent problems in the concept (such as the catch-all nature of the criteria) lead us to the firm conclusion that MSbP is an unreliable and non-valid diagnosis. The authors of these guidelines do not appear aware of these criticisms or, if they are aware, have chosen to ignore them.	
SH	Public Health Research Group	33	FULL	7.1	84	Line 25: "Attachment" is another example where there needs to be an **alert** drawing attention to specific areas that have been subject to diagnostic controversy, misdiagnoses, miscarriages of justice and disproportionate child protection interventions. Current child protection practice (especially the promotion of hostile adoptions) is adversely affected by the misapplication of attachment theory in forensic contexts.	Thank you for this comment, but the guidance is explicitly about when to suspect child maltreatment and is not intended as a diagnostic manual nor is it intended to direct more specialist assessments within child care proceedings.
SH	Public Health Research Group	34	FULL	7.1	84	Line 34: It needs to be noted that 'insecure attachment' is not necessarily pathological and is common in the general population (and across cultures). "Insecure attachment' can	Thank you for this comment. This consideration had informed the GDG's deliberations on this matter.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						also have positive benefit (e.g. as part of resilience, and with some high achievers).	
SH	Public Health Research Group	35	FULL	7.1	85	Line 35: states "the attachment literature uses hypothetical scenarios to measure attachment." There is no academic/clinical consensus about such "measures", and their validity should not be accepted in forensic settings.	Thank you for this comment. This consideration had informed the GDG's deliberations on this matter, within the context of recognising the guideline is not intended for use in 'forensic settings'.
SH	Public Health Research Group	36	FULL	7.2.3	95	Lines 22-23 report that "The GDG did not identify a good evidence base for whether a history of recurrent abdominal pain is a reason to suspect child maltreatment." Nevertheless in lines 30-32, the GDG proceeds to recommend that "Healthcare professionals should consider child maltreatment when a child has recurrent abdominal pain in the absence of a medical cause or other stressor unrelated to maltreatment, for example illness in the family, parental separation etc." This is a perfect example of the type accusation without foundation that has caused the crisis of credibility that Child Protection now experiences.	Thank you for your comment. The GDG has now removed this recommendation and made a research recommendation.
SH	Public Health Research Group	37	Full	Apx A	108	Several members of the Guideline Development Group have failed to register significant conflicts of interest here.	Thank you. We have modified this table so that where a GDG member has not declared any interests, "No interests declared" is stated. We have updated the lists according to NICE's Declaration of Interests policy, which can be found here: **http://www.nice.org.uk/niceMedia/pdf/GDG_Declarations_of_Interest.pdf**
SH	RCPCH	0	Full	7.2.5	97	*"The GDG believes that the possibility of maltreatment as a precursor for selective mutism needs to be considered."*	Thank you very much for this comment. The GDG acknowledges this was an area where we have been able to consider the issue

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						I believe this is an incorrect statement. You may be confusing selective mutism with 'traumatic mutism'. While cases of mutism have occurred as a result of a child being abused or emotionally or physically traumatized, it seems to be very rare. In recent systematic studies no selectively mute children were found to have a history of speaking normally until a traumatic incident. References: Black B. Uhde TW. *Psychiatric characteristics of children with selective mutism: a pilot study.* Journal of the American Academy of Child & Adolescent Psychiatry. 34(7):847-56, Jul 1995. Dummit ES 3rd. Klein RG. Tancer NK. Asche B. Martin J. Fairbanks JA. *Systematic assessment of 50 children with selective mutism*. Journal of the American Academy of Child & Adolescent Psychiatry. 36(5):653-60, May1997. Rather than being related to maltreatment, "selective mutism is now acknowledged as an anxiety condition which appears to lie on a spectrum between shyness and severe social phobia." Reference: Selective Mutism: A consensus based care	afresh as a result of your comments and the recommendation has been removed. Furthermore the definition and the text have been revised to acknowledge that selective mutism is probably an anxiety disorder and it is different from traumatic mutism.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						pathway of good practice *Arch. Dis. Child. 2009* Keen D, Fonseca SF, Wintgens A There is now no evidence that Selective Mutism has significant relationship to maltreatment or history of trauma. The main associations are with developmental disorders, bilingualism and family history of anxiety disorder. References: Steinhausen H and Juzi C. 1996. *Elective Mutism: An analysis of 100 cases.* Journal of the American Academy of Child and Adolescent Psychiatry. Kristensen, H. 2000. *Selective Mutism and comorbidity with developmental disorder/delay, anxiety disorder and elimination disorder*. Journal of the American Academy of Child and Adolescent Psychiatry, 39, 249-256. Cunningham, C.E., Mc Holm, A., Boyle M.H. & Patel, S, 2004. *Behavioural and emotional adjustment, family functioning, academic performance and social relationships in children with selective mutism.* Journal of Child Psychology and Psychiatry, 45 (8), 1363-1372. Vecchio J.L., and Kearney, C.A. 2005. *Selective Mutism in Children: comparison to youths with and without anxiety disorders,* Journal of Psychopathology and Behavioural Assessment, 27(1), 31-37.	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	RCPCH	1	Appendix A		108	This should be omitted. These are not "Declarations of Interest" in the usual sense (potential conflicts of interest). They are authors' qualifications, relevant experience, and publications they are proud of! You could call the appendix "brief biographies" or "résumés". If you mean Declarations of Interest then give such things as fees received from campaigning groups or representing parties in legal disputes etc.	Thank you. We have made modifications to the presentation of this information where required. However, the extensive nature of the interests declared is also attributable to the NCC-WCH's implementation of the NICE policy which requests both personal pecuniary and non-pecuniary as well as non-personal pecuniary and non-pecuniary interests to be declared. Advice received from NICE has been to err towards over-declaring interests to avoid any material conflicts of interest being undeclared.
SH	RCPCH	2	Appendix C	General	General	Comments as for section 1.1.2	Noted and responded to as in the comments on section 1.1.2.
SH	RCPCH	3	Full	1.1	14	Please omit the sentence in brackets. The change in nomenclature from CP register to CP plan is petty, and not worth highlighting in the opening paragraph of such a major work. If it has to remain at least say 'subject to a CPP' rather than 'subject of'.	Thank you for your comment. The data have been updated to 2008 figures so no reference is made to the child protection register. The wording "subject of" appears in Every Child Matters; the GDG wishes to retain this form of words.
SH	RCPCH	4	Full	1.1.2	7	The College is concerned that among the options for suspected abuse, referral to social care is not listed. Whilst the College appreciates that the document is aimed at the non-specialist, it is vital that if children are to be safeguarded that such people feel able to make a referral if they feel the evidence warrants it, rather than being caught in a spiral of indecision and ineffective intervention (see paragraph 11.2 of 'What to do if you're worried a child is being abused, DCSF 2006). To quote an example from a part 8 review, '[The Nurse] did not pursue it further because she was a nurse and the doctor was a consultant'	Thank you for drawing this to our attention. This was implicit in the sentence which said 'follow local guidance on what to do…'. This has been amended to read: "refer the child or young person to children's social care, following Local Safeguarding Children Board procedures." in the light of your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						(See 'Analysing Child Deaths and Serious Injury through abuse and neglect: What can we learn? A biennial analysis of serious case reviews 2003-2005' DCSF RR0230)	
SH	RCPCH	5	Full	1.1.2	7	Should not taking the history directly from the child be mentioned? (See Climbie enquiry rec 65)	Thank you for your comment. We hope that the following recommendation addresses this concern: 'Seek an explanation for any injury or presentation from both the parent/carer and the child or young person in an open and non-judgemental manner.
SH	RCPCH	6	Full	1.2		There is some concern that this will be seen as yet another piece of guidance when, as Lord Laming pointed out, there is already too much confusion with multiple sources of guidance. Having said that, the narrow scope of this guidance is useful and it does cover a relatively neglected area, therefore overall this is useful. It should be made very clear that this does not replace the guidance in *Working Together*, or LSCB guidance in relation to child protection procedures.	Thank you for your comment. As you have identified, the remit of this guidance is narrow and, as such, provides specific guidance that until now has not been represented elsewhere. As the GDG is directing health professionals towards LSCB guidance, it is clear that the two must be used together.
SH	RCPCH	7	Full	1.2.7	9	The list of barriers to effective intervention omits one of the most significant and paralysing: fear for the worker's personal safety. (See 'In memory of Ainlee Walker', pub BASW 2003).	Thank you for your comment. 'Personal safety' has been added to the list of deterrents.
SH	RCPCH	8	Full	1.3.29	17	This implies that Sexual intercourse in those over 13 is legal which is untrue.	Thank you for your comment. There are separate recommendations for children over the age of 13 years so, when read as a set, your statement, while logical, does not apply.
SH	RCPCH	9	Full	1.4		There is some concern as to how many front line professionals would ever read or use a document of this size. It is a useful reference, and helpful for trainers, but likely to be of	Thank you for your comments. We have been working with the editorial team at NICE to produce a quick reference guide that we hope will be useful for the intended audience.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						limited use to those groups listed.	
SH	RCPCH	10	Full	1.5	15	On p.5 GDG seems to have 3 cons community paeds and 1 hospital paed not the other way round	Thank you for highlighting this. This change has been made.
SH	RCPCH	11	Full	1.7		Synthesis of clinical evidence – The College is concerned by the implication that the framework used for analysing the evidence is that developed for analysing intervention studies, whereas the questions asked in this review are those around recognition and diagnosis. For these questions RCTs are mostly inappropriate, and case-control, cohort, observational and qualitative studies are likely to be more valid. This should be taken into account and an appropriate framework used to assess the validity of studies.	Thank you for this comment. This matter was discussed at the beginning of the guideline development process and a decision was made to keep the development process as close to the usual NICE process as possible, hence this grading of the evidence. This framework permits the inclusion of observational studies.
SH	RCPCH	12	Full	Glossary	12	Hymenal laceration definition is not quite the same as the RCPCH 'Physical Signs in Sexual Abuse' The guidance should ensure that there is consistency between all documents used.	Thank you. We agree that consistency here is of utmost importance. This was our intention but we would agree that we have abbreviated the definition of hymeneal laceration and have therefore amended to "A fresh wound made by tearing through the hymen which may be partial or complete."
SH	RCPCH	13	Full	2	23	The names of micro-organisms should be written in the correct format; this is for first part of the species name to be capitalised and the second part to have a lower case letter; the convention is also for the name to be italicised in print; viz: *Neisseria gonorrhoeae; Chlamydia trachomatis; Trichomonas vaginalis.* This error occurs in various places in the document	Thank you. The final version of the guideline will follow the RCOG Press publishing conventions (for the full guideline) and the NICE style guide (for the NICE guideline and quick reference guide, etc).
SH	RCPCH	14	Full	2	24	It is important to separate out consider and suspect when describing general features of neglect as they are all together.	Thank you for this suggestion. We have been working with the editorial team at NICE to decide how best to present these

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							recommendations.
SH	RCPCH	15	Full	2.1	20, lines 25+	The College is concerned that a broad generalisation such as "review the child at a later date" could lead to unnecessary delay in seeking advice / taking action. Is there evidence to support such a course of action? If not this point should either be omitted or else a specific time frame should be given if there is a time frame for such an approach.	Thank you for this comment. We have changed the wording to read "ensure review the child or young person at a *date appropriate to the concern*, looking out for repeated presentations of this or any other alerting feature." We feel that we cannot be more prescriptive than this because the length of time depends on a number of factors. We have not sought evidence on this matter but believe it to be good practice. We hope this change is helpful.
SH	RCPCH	16	Full	2.1	Pg 20, line 35	Unclear what is meant here do you mean that the history given by a parent / carer changes over time?	Thank you for your comment. This has been clarified in the recommendation. Inconsistency refers to differences over time and/or between different people.
SH	RCPCH	17	Full	2.1	Pg 21, line 4/5	This should also state that disabled children, including those with behavioural disorders, are particularly vulnerable to abuse.	Thank you for your comment. Disability in children has been added to the list of risk factors for maltreatment.
SH	RCPCH	18	Full	2.1	Pg 22, line 13	This does not reflect the published evidence, should read "full thickness contact burns with clearly demarcated edges or a contact burn in an unusual location (eg iron burn on the back of the hand) or multiple identical contact burns".	Thank you. Our search for evidence identified a paucity of studies in this field. We were limited to case studies. The GDG consensus did not agree that the evidence was strong enough to justify the degree of burn thickness within its recommendation but did feel that the unusual site was relevant.
SH	RCPCH	19	Full	2.1	Pg 22, line 31	Particular concern should be raised by the presence of femoral fractures in the non-mobile child, or non-supracondylar fractures of the humerus in a young child.	Thank you for your comment. As stated above, the GDG hoped that front-line professionals would raise concern regarding any unexplained fracture in children under 18 months. The GDG felt that there were dangers in expecting front line professionals to make a judgement on the likelihood of abuse on fracture type as this is an area for expert

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							assessment.
SH	RCPCH	20	Full	2.1	Pg 22, line 44	Should say "extensive retinal haemorrhage, unlilateral or bilateral, particularly if extending beyond the posterior pole, in a child where organic disease such as coagulopathy has been excluded, and where such haemorrhage has been recorded on dilated indirect opthalmoscopy.	Thank you for this comment, We have considered this but as the guidance is for front-line workers we would wish anyone who sees retinal haemorrhages to refer a child for further assessment. This information is relevant to ophthalmologists who are involved in the detailed assessment of the child and as such is outside the scope of the guidance.
SH	RCPCH	21	Full	2.1	Pg 22, line 48	Inconsistent with what?	Thank you for your comment. A definition of an unsuitable explanation has now been provided at the beginning of the document, including a guide to 'inconsistency'.
SH	RCPCH	22	Full	2.1	20-28	These recommendations are very thorough, broad in scope and appropriate.	Thank you.
SH	RCPCH	23	Full	2.1	22 – line 32	This is a well written and sensible paragraph regarding intracranial injuries.	Thank you.
SH	RCPCH	24	Full	2.1	23 – line 1	This is a well written and sensible paragraph regarding spinal injuries.	Thank you.
SH	RCPCH	25	Full	2.1	23, line 9	Visceral injuries – should state after "intra-abdominal" particularly ruptured or perforated duodenum in children less than five years, or ruptured liver / spleen without significant history of trauma.	Thank you for this suggestion. These types of injury are covered in the recommendation.
SH	RCPCH	26	Full	2.1	24	Poor wording: "pregnancy constitutes maltreatment". Pregnancy implies or indicates, it does NOT constitute abuse.	Thank you for these suggestions. This text has been changed to "means".
SH	RCPCH	27	Full	2.1	21	The College welcomes the phrase 'no intention to harm the child'. Professionals often get very confused about referral if there are adults attributes eg LD that may influence referral, whilst ignoring the experience of the child.	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	RCPCH	28	Full	2.1	26	The College is pleased that 'Emotional, behavioural and interpersonal/social functioning' is covered so extensively – this is an area that is very difficult to get recognized as being secondary to maltreatment. In particular those conditions eg soiling/wetting that present to general paediatrics.	Thank you for your comment.
SH	RCPCH	29	Full	2.2	29	Given the potentially very poor outcomes from cranial trauma and the lack of knowledge in this area, the College is surprised this wasn't a priority for research.	Thank you for this suggestion. This research topic is outside the scope of the guidance so has not been put forward.
SH	RCPCH	30	Full	2.2	29	The priorities for research are good. Translating these into achievable research projects is likely to be extremely difficult, particularly with the research recommendation in relation to FII.	Thank you for your comment.
SH	RCPCH	31	Full	2.4	31	The flowchart is very helpful. It should be cross-referenced to the relevant sections in *Working Together* and *What to do if you're worried.* Some comment should be added in relation to discussing concerns with parents/ carers and when not to do so, and on the importance of / professional responsibility and authority to share information with other professionals – this could simply be based on the guidance in *Working Together* and *What to do if you're worried.*	Thank you for your comment. The flowchart represents the guideline development group's definitions of 'consider' and 'suspect' and their associated actions within the context of this guidance.
SH	RCPCH	32	Full	2.4	32, line 21	Fear of losing positive relationship with a family already under the care of the health professional for organic disease.	Thank you for this helpful suggestion. The following has been added: "fear of losing positive relationship with a family already under their care"
SH	RCPCH	33	Full	2.4	P31	Flow chart: on R side, 3rd box has the word	Thank you for drawing this to our attention.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						'concern' missing	Typos have been corrected in the revised version of the guideline
SH	RCPCH	34	Full	3	32	This background is very helpful	Thank you.
SH	RCPCH	35	Full	3	37	The recommendations imply that every child seen for bruising and suspected physical abuse should have blood tests. This is not currently the case and there should be professional leeway e.g., single bruise in the shape of an implement.	Thank you for drawing this to our attention. This was not the intended message and the wording has been changed to clarify this. Causative coagulation disorder is now given as an example of a relevant medical condition. "Suspect child maltreatment if a child or young person has bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a coagulation disorder)..." The first recommendation allows for a single bruise in the shape of an implement to be a reason to suspect maltreatment.
SH	RCPCH	36	Full	3	General	Is it worth mentioning association between animal maltreatment and child maltreatment somewhere?	Thank you for raising this. We have added animal abuse to the list of risk factors in this section.
SH	RCPCH	37	Full	3.1	33	Under the recommended action for both Suspect maltreatment and consider maltreatment, it would be beneficial to add that "the parents /carers should be informed of the professional's concerns unless to do so might put the child or someone else at risk of harm, or may jeopardise any police investigation"	Thank you for this suggestion. Unfortunately, communication with parents/carers about suspicions is outside the scope of this guidance.
SH	RCPCH	38	Full	3.1	33, line 33	Or removal of the perpetrator from the family home	Thank you for this suggestion. This has been added.
SH	RCPCH	39	Full	3.1	34, line	As before, an open ended recommendation such as "review at a later date" seems a very dangerous approach, if there is no evidence for this statement, it would be safer to remove it, and leave the option to discuss with a qualified colleague, which may lead to a further	Thank you for this comment. We have changed the wording to read "ensure review the child or young person at a *date appropriate to the concern*, looking out for repeated presentations of this or any other alerting feature." We feel that we cannot be more

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						review at a specified time in the future.	prescriptive than this because the length of time depends on a number of factors. We have not sought evidence on this matter but believe it to be good practice. We hope this change is helpful.
SH	RCPCH	40	Full	3.1	34 line 26-29	This section should detail why a professional needs to discuss with another professional e.g., to prevent harm to both the child and other children.	Noted with thanks.
SH	RCPCH	41	Full	3.1	33-34	The guideline should separate boxes for suspect and consider to make it clearer	Thank you for this suggestion. We have been working with the editorial team at NICE to identify the best way to highlight the importance of understanding consider and suspect and have taken note of your suggestion.
SH	RCPCH	42	Full	3.2	35	The document could be reduced by cross referencing to the definitions in Working Together. If the definitions are to be included then the definitions for: • exposure to domestic abuse • prostitution • exploitation or corruption of children and young people, including trafficking should also be included.	Thank you for your comment. The GDG believes it necessary to include the definitions here. However, the recommendation has been removed and readers referred to the supplementary guidance in Working Together.
SH	RCPCH	43	Full	1.7	17	Table 1.1 Levels of evidence for intervention studies. Most of the studies in child abuse and neglect are not intervention studies, they are most often descriptive. Was this an appropriate criteria applied to levels of evidence fro this guideline?	Thank you for this comment. This matter was discussed at the beginning of the guideline development process and a decision was made to keep the development process as close to the usual NICE process as possible, hence this grading of the evidence.
SH	RCPCH	44	Full	4.1	36, line 34	The additional information regarding the significant association between bruising with petechiae and abuse (Nayak 2006) should be	Thank you for your comment. The evidence presented to the GDG to draw up this recommendation included the published

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						added to this result, (part of update of this systematic review as hosted on www.core-info.cf.ac.uk)	systematic review by Welsh Child Protection Systematic review group together with the update as cited on **www.core-info.cf.ac.uk** that includes the Nayak 2006 paper.
SH	RCPCH	45	Full	4.1.	50, line 6	It is clear in the literature (Morad et al, full reference can be provided if necessary) that non-opthalmologists have a lower sensitivity in detecting retinal haemorrhages than opthalmologists, they are unable to complete the examination or miss the findings in up to 13% of cases. In addition, the precise pattern (identification of which layer/s of the retina are involved, or regions of the retina) requires dilatation and use of the indirect opthalmoscope, and this is vital to distinguish inflicted from non-inflicted retinal haemorrhages.	Thank you for this comment. The recommendation implies that, should a health professional observe a retinal haemorrhage, they should suspect maltreatment provided the other specified causative reasons have been ruled out. The GDG recommendation does not state that all health professionals should look for retinal haemorrhages.
SH	RCPCH	46	Full	4.1.	51, line 5,6	Another major cause of accidental spinal injuries in children is sports, this should be included with MVC. There are unsubstantiated reports in the literature of abusive spinal injuries, so the statement that "the literature reports only cases where there were confessions" etc is inaccurate. It should be noted here however that unstable cervical spinal fractures may be missed unless specifically screened for, as "hangman's" fractures as a consequence of abuse are described.	Thank you for this comment. Sports injury has been added. The wording about reports in the literature has been changed to "The substantiated cases of maltreatment in the literature were where there were confessions…" Your third point is outside the scope of the guidance as it refers to investigations after maltreatment has been suspected.
SH	RCPCH	47	Full	4.1.	52, Line 20	The statement visceral injuries occur more commonly in non-accidental than accidental injury is not substantiated by any of the studies quoted above, where the commonest cause of	Thank you for highlighting this. This sentence has been amended to improve clarity.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						visceral injuries was MVC, having excluded MVC as a cause, abuse remained the commonest cause in the youngest children.	
SH	RCPCH	48	Full	4.1.1	36 line 7	The following should be added 'However they can still be abused'.	Thank you for your comment. This is a true statement but is not specific to bruising.
SH	RCPCH	49	Full	4.1.1	37 line 27	The sites noted in p36 line 28 should be added. Also, important to state that bruising to the hand in children less than four years rare in accidental injury.	Thank you for your comment. 'Bruises other than on bony prominences' covers the areas you suggest and we are unable to provide an exhaustive list of examples.
SH	RCPCH	50	Full	4.1.10 4.1.12	51 line 8 line 16 53	Consistency in terminology throughout the document. A further new term is introduced… Cause for concern.' that the absence of an appropriate explanation should be a cause for concern' or raise a concern	Thank you for your comment. The words "and thus a reason to suspect maltreatment." have been added to the sentence on page 51. On page 53, the text has been changed to "should raise awareness about the possibility of child maltreatment."
SH	RCPCH	51	Full	4.1.11	51, Line 27	Need to add ruptured oesophagus, with or without insertion of foreign bodies by an adult.	Thank you for this suggestion. This type of injury is covered in the recommendation.
SH	RCPCH	52	Full	4.1.11	53, 37	As before, this is misleading. Abusive abdominal injury is frequently associated with bruising, but not necessarily abdominal bruising (absent in up to 40% of cases). Abdominal distension is an almost ubiquitous feature, and co-exixtent fractures are frequently recorded. Also worth noting that elevated liver enzymes or amylase are frequently found in abusive abdominal injury.	Thank you for this information. This introductory text is about the difficulties of making a diagnosis of visceral injury.
SH	RCPCH	53	Full	4.1.2	37	Some comment on difficulties of differentiating adult from child bite should be included. Multiple child bites are of concern as reflect supervision of children i.e. neglect.	Thank you. We have added a sentence to say how difficult it is to recognise adult from child bites together with information in the introduction that forensic evidence can help to identify a perpetrator.
SH	RCPCH	54	Full	4.1.2	38	The College is not convinced that there is any	Thank you for your comment. The GDG

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						published evidence on distinguishing adult from child bite marks. Such an assessment should perhaps be in the realm of a forensic odontologist. The guideline should be cautious about including the phrase "suspected to be caused by an adult" and it may be more appropriate to state that "healthcare professionals should consider maltreatment where there is a report or appearance of a human bite mark on a child." However, the statement used has been arrived at by a Delphi process, so is valid within that level of evidence. Perhaps some qualifying remark referring to the absence of evidence is required.	agrees that a forensic specialist is required to distinguish between child and adult bite marks. The GDG has decided to replace "suspected to be caused by an adult" with "that is thought unlikely to have been caused by a young child" and has made a statement about its decision to change the Delphi statement.
SH	RCPCH	55	Full	4.1.2	39, line 13	Given the difficulty in distinguishing adult / child bite marks with the naked eye, this recommendation should state that all suspected bites should be referred to a Forensic dentist, who provide an on call service. This is vitally important as forensic DNA evidence may be retrievable, as well as the possibility of reconstructing the perpetrators dentition from use of CT scanning etc. Note should also be made here of the need for clinical photographs of any suspected bite, taken with a right angled measuring device in the photo, and taken in more than one plane if the bite is on a curved surface (as per www.bafo.uk website).	Thank you. This is appropriate advice; however, investigation of the child with suspected abuse is outside of the scope of the guidance.
SH	RCPCH	56	Full	4.1.2 12-13	39	Healthcare professionals should suspect child maltreatment when there is a report or appearance of a human bite mark, on a child, suspected to be caused by an adult.	Thank you for your comment. The GDG agrees that a forensic specialist is required to distinguish child from adult bite marks. The GDG has decided to replace "suspected to be

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						How will the healthcare professional distinguish between an adult or a child's bite? Surely an older child/teenager (<18) biting a young child is abusive?	caused by an adult" with "that is thought unlikely to have been caused by a young child" and has made a statement about its decision to change the Delphi statement.
SH	RCPCH	57	Full	4.1.2	39	Healthcare professionals should consider neglect when there is a report or appearance of an animal bite in a child who has been inadequately supervised. Why should we only consider neglect in animal bites? Animals can be incited to attack and to be used as weapons.	Thank you for this suggestion. The comments from the Delphi panel indicate that 'suspect' is too strong because it depends on the animal. 'Consider' allows the healthcare professional to think about the circumstances around the bite before going on to suspect abuse if appropriate.
SH	RCPCH	58	Full	4.1.3	39	We should use the correct medical term and define it e.g. cut should be laceration.	Thank you for the comment. We have changed 'cut' to 'laceration (cut)' because the audience of this guidance is wider than doctors. This section has been amended to ensure clarity.
SH	RCPCH	59	Full	4.1.3 1-6	40	The recommendations go from the term cuts/abrasions/scars to the term 'an injury' to ….. (injuries can be bruising, burns etc). For consistency lines 1-6 injury should be replaced with cuts bruises or scars	Thank you for pointing this out. This change has been made.
SH	RCPCH	60	Full	4.1.3	40 line 2	Cross reference genital injury to sexual abuse section or remove and leave in sexual abuse. This may confuse professionals around whether genital injuries in the context of maltreatment should be seen as physical injury or sexual abuse. Genital injury in particular should make reference to straddle injury.	Thank you for your comment. The reference to the genital area has been given as an example in 'areas usually protected by clothing'.
SH	RCPCH	61	Full	4.1.4	40 line 10	This should read "60degrees" not 100, as per Dressler.	Thank you for highlighting this. This change has been made.
SH	RCPCH	62	Full	4.1.4	40, line 12	Or radiation eg microwave	Thank you. We have aimed for the introductory paragraph to be illustrative rather than entirely comprehensive and appreciate these two

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							uncommon causes. We hope that microwave burns might be covered by "electrical" items. Radiation burns would also need some explanation that we felt was outside the scope. However, other comments have included a need to consider sunburn and this is now referred to in a neglect recommendation. We have cross referenced the thermal injury recommendation to neglect.
SH	RCPCH	63	Full	4.1.4	40 line 27	The document has now introduced another term 'likely'. What is the difference between suspect, consider, alerting feature and likelihood of… The following features indicate that intentional scalds are likely….	Thank you for your comment. The terms 'consider' and 'suspect' have operational definitions that relate to the recommendations. Terms such as 'likely', 'alerting feature' and 'likelihood of' have been used in the background text that underpins the recommendations. They retain their usual meanings.
SH	RCPCH	64	Full	4.1.4.	40	Thermal injuries should make reference to cigarette burns in the opening para. They are referred to later on line 16 page 41. Reference should also be made to the difficulty in determining cause in older or infected burns as the shape may change.	Thank you for the comments. We hoped that we have covered cigarette burns in terms of the lack of evidence and using them as an example in the recommendation regarding a contact burn in the shape of implement used. We fully appreciate that cigarette burns are well recognised in abuse. However, the published evidence to distinguish abusive from non–inflicted burns is very limited. The second point refers to the evolution of a burn and as such was outside the scope of the literature review. Burns less frequently result from flames, chemicals, electrical items and accidental contact with cigarettes. Difficulties of recognising that a lesion is a burn

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							and differential diagnosis is outside the scope of this guidance.
SH	RCPCH	65	Full	4.1.5	42	The guideline should consider whether there is any evidence in relation to sunburn.	Thank you. We have considered the availability of evidence and used this as an example in neglect.
SH	RCPCH	66	Full	4.1.6	42 Line 26,29/ 30	line (26)… The GDG identified no literature that suggests spontaneous hair loss occurs secondary to maltreatment. Where is the literature to support the subsequent statement 'Hair loss due to self-inflicted hair pulling may be a sign of emotional distress that could be due to maltreatment in the absence of a medical cause or other definable stressor'.	Thank you for highlighting this. The statement was made based on GDG consensus and this has now been clarified in the text.
SH	RCPCH	67	Full	4.1.7	46 Line 20	A further term has been introduced 'indicative'. How does this differ from suspect, consider, alerting feature, likelihood of… and indicates.	Thank you for your comment. The terms 'consider' and 'suspect' have operational definitions that relate to the recommendations. Terms such as 'likely', 'alerting feature' and 'likelihood of' have been used in the background text that underpins the recommendations. They retain their usual meanings.
SH	RCPCH	68	Full	4.1.7	P44, line 8	'..child know to social service'. 'S' missing, should be 'services'.	Thank you. This has been amended to 'children's social care'.
SH	RCPCH	69	Full	4.1.8	48	This is a useful summary of both published and unpublished work relating to intracranial injury with a sensible conclusion.	Thank you.
SH	RCPCH	70	Full	4.1.8	48 line 1	The guideline should include a comment on hypoxic ischaemic injury as white matter changes on MRI scan for lay people and others without specific knowledge in this area.	Thank you for your comment. Thank you for this comment. Hypoxic ischaemia has been added to the glossary as *damage to the brain due to lack of blood and oxygen supply*
SH	RCPCH	71	Full	4.1.8	48 line 41-6	This needs clarification. Although there is evidence about infant toddler the College is unsure about how it is currently worded:	Thank you for your comment. We have amended this section to improve clarity. We hope the change is helpful.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						suspect child maltreatment in any child, then bullet point about infant/ toddler.	
SH	RCPCH	72	Full	4.1.8	47 line 12	Should we be including unpublished work?	Thank you for your comment. This is a good question. This was a pragmatic decision because the technical team was aware the work was being completed.
SH	RCPCH	73	Full	4.1.8.	48 line 33	How do you define moderately ill?	Thank you for your comment. This phrase has been removed and replaced with "non-specific symptoms such as vomiting and irritability".
SH	RCPCH	74	Full	4.1.9	49, linew 9	This list should also include caustic injury, penetrating injury (eg with a needle). The statement "retinal haemorrhage is often associated with trauma to the head, particularly in the context of shaken baby syndrome" should be reworded. Firstly the term "shaken baby syndrome" is no longer used, and should be replaced with the term "inflicted head trauma" or "abusive head trauma", as will be recommended also in the forthcoming American Academy of Paediatrics. Secondly, the current wording implies that retinal haemorrhage is common in head trauma of other aetiologies, which is not substantiated by the literature. Retinal haemorrhage is found in 1-4% of accidental head trauma, maximum prevalence of 10% in severe head injury, warranting ITU admission, and has been described specifically in relation to severre crush injuries or in association with extradural haematoma, a rare finding in inflicted head trauma.	Thank you for pointing this out. "Shaken baby syndrome" has been changed to "abusive head trauma". Thank you. We have amended the section regarding retinal haemorrhages. We have included penetrating injury.
SH	RCPCH	75	Full	4.2	53-60	Although this section is based on the RCPCH guide on 'Physical Signs of Child Sexual Abuse', the College am concerned that the	Thank you for your comment. There are reasons why the two differ. The target audience is different. The guideline identified

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						terminology and recommendations in this section do not fully match those in the RCPCH guide.	symptoms as well as signs of CSA. It relies upon lowering the threshold for recognition of suspected CSA to encourage front line healthcare professionals who do not have the expertise to interpret signs fully. It is also written to be generic and applicable to boys as well as girls. Specific genital lesions are not specified in detail. Health professionals need to think of CSA when presented with a genital injury.
SH	RCPCH	76	Full	4.2	63	This section contains some poor wording: "pregnancy constitutes maltreatment". Pregnancy implies or indicates, it does NOT constitute abuse.	Thank you for these suggestions. This text has been changed to "means".
SH	RCPCH	77	Full	4.2.2	54 line 20	Some comment should be added to state that there was 1 comparative study to balance comment on p55 line 29.	Thank you for your comment. Where comparative studies exist, they have been cited in the relevant sections.
SH	RCPCH	78	Full	4.2.2	55 line 1	This section contains some spelling mistakes: Lacerations 'were' reported. 'Where' not 'were' on line 2.	Thank you for pointing this out. This has been amended to correct typos.
SH	RCPCH	79	Full	4.2.2	56	Anal tags should be under a separate heading. Line 5 contains a typo 'anal' not 'and'.	Thank you. Both of these changes have been made.
SH	RCPCH	80	Full	4.2.2	58	The recommendation that Healthcare professionals should suspect sexual abuse when a girl or boy has a gaping or dilated anus in the absence of medical causes such as neurological disorders or very severe constipation seems to have no basis in the research evidence and is not in keeping with the RCPCH guidance.	Thank you for your comment. The GDG has reached this decision by consensus. The GDG believes that this finding requires further investigation.
SH	RCPCH	81	Full	4.2.2	58 line 22-23	The College is unsure where the recommendation relating to gaping/ dilated anus has come from. The College is not aware of any evidence to support this	Thank you for your comment. The GDG has reached this decision by consensus. The GDG has amended this recommendation to read "Consider sexual abuse if a gaping anus in a

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						recommendation, nor in Delphi process. This should be removed.	girl or boy is observed during an examination, and there is no medical explanation (for example a neurological disorder or very severe constipation)." This is in line with the recommendation in the RCPCH document and takes into account the expertise of frontline health professionals who may not know how reflex anal dilatation is defined nor would be expected to look for it.
SH	RCPCH	82	Full	4.2.2	54-55 line18/ 19	There is a mixture of the interpretation of the evidence and no interpretation of the evidence for the various physical signs e.g **Labial Fusion:** There is insufficient evidence to determine the importance of labial fusion in sexual abuse of pubertal girls Vs. **Oedema:** No studies were identified that reported the prevalence of oedema in non-abused girls. Oedema was noted in 19% (n=214) of pubertal sexually abused girls. The timing of examination after the alleged incident influences the finding of oedema. Either the section needs to cross reference with the Physical Signs in CSA or provide more information on the interpretation of each sign i.e. include the evidence statements.	Thank you for your comment. We have clarified in the text that the findings presented in this section are summaries of the findings in the RCPCH document.
SH	RCPCH	83	Full	4.2.2	58 Line 20	Healthcare professionals should suspect sexual abuse when a girl or boy has an anal or perianal injury (as evidenced by bruising, laceration, swelling, abrasion) with an absent, implausible, inadequate or inconsistent explanation for the injury.	Thank you for your comment. Swelling is given as an example of an anal or perianal injury. The audience for this guidance is different to that for the RCPCH document on the physical signs of sexual abuse. The GDG believes that an anal injury without a suitable explanation

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Swelling has no evidence base, statements need to be cross referenced in terms of terminology with other publications	requires further investigation.
SH	RCPCH	84	Full	4.2.2	58 line 22/23	Healthcare professionals should suspect sexual abuse when a girl or boy has a gaping or dilated anus in the absence of medical causes such as neurological disorders or very severe constipation. Should this be Reflex Anal Dilatation? Not synonymous with the terms from RCPCH Physical Signs?	Thank you for your comment. The GDG has used the RCPCH definition of gaping in its glossary.
SH	RCPCH	85	Full	4.2.2	58 line 5 - 25	Recommendations include a mixture of symptoms and signs but only some of the signs with the emphasis on anal signs and no clear recommendations regarding the female genital signs. Why?	Thank you for your comment. We have included signs and symptoms which is another area where this guidance differs from RCPCH CSA document. The GDG has aimed to produce generic recommendations as we would want health professionals to have a low threshold for considering/suspecting CSA that is applicable to boys and girls. The recommendations are written in this way as we do not expect a front-line healthcare professional who is confronted with this situation to conduct a detailed assessment. They will need to refer a child on for further consideration.
SH	RCPCH	86	Full	4.2.3	21	The statement on syphilis on this line correctly identifies the lack of evidence for sexual transmission in childhood. However a similar statement for Hepatitis B is qualified by a recommendation that sexual abuse should be considered if vertical, perinatal or blood contamination have been excluded. A similar statement should be appended to the syphilis statement. Furthermore, for syphilis, the stage	Thank you for your comment. The qualification of the hepatitis B statement is an interpretation of the evidence and was included in the evidence section for this guidance erroneously. It has now been removed and no further addition to the evidence on syphilis has been made.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						of infection may be relevant. A child presenting with a primary lesion or secondary rash, for example, should be suspected of being a victim of sexual abuse whereas a child with positive tests for syphilis may have these results as a result of vertical, perinatal or blood contamination	
SH	RCPCH	87	Full	4.2.3	61	The College is concerned about the recommendation that sexual abuse should be suspected (rather than considered) in a child under 13 with an STI unless there is clear evidence of mother to child transmission or blood contamination. The evidence around some STIs (particularly anogenital warts) is mixed and evidence of mother child transmission will not always be present.	Thank you for your comment. The GDG agrees with comment and has made a separate recommendation about anogenital warts in this age-group at the consider level.
SH	RCPCH	88	Full	4.2.3	61	There is significant concern about these recommendations in relation to <13 years. The RCPCH CSA guidelines state that CSA should be 'considered' for anogenital warts, genital herpes, hepatitis b and c. These recommendations state 'suspect CSA' in child below 13 years. The evidence is not strong enough, and this would lead to inappropriate referrals. There may be medical reasons for AGW eg self inoculation from child's hands which is not considered.	Thank you for your comment. The evidence identified by the RCPCH in its recent document suggests a high prevalence of sexually-transmitted ano-genital warts (between 31 and 58% of ano-genital warts in children). However, the GDG notes your view and has made separate recommendations for each age group about anogenital warts that account for household transmission; all are at the consider level.
SH	RCPCH	89	Full	4.2.3		In contrast to the above comments each STI is provided with the likelihood of CSA. We don't therefore understand why there was a Delphi consensus. The GDG's consideration without the Delphi consensus would seem appropriate.	Thank you for your comment. The GDG sought the views of the Delphi panel because of issues around age of consent and how that is managed in practice. The age of consent question does not apply in quite the same way with ano-genital signs and symptoms.
SH	RCPCH	90	Full	4.2.3	61	Recommendations	Thank you. We appreciate your comment. The

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					Line 29-33	Healthcare professionals should consider sexual abuse when a young person aged 13 to 15 years presents with any sexually transmitted infection (such as neisseria gonorrheae, chlamydia trachomatis, syphilis, anogenital warts, genital herpes simplex, hepatitis B and C, HIV and trichomonas vaginalis) unless there is clear evidence of blood contamination or that the STI was acquired from consensual sexual activity with a peer. We do not agree that this should be **suspect** not consider. As you are excluding the non CSA causes.	front-line professional may not be in a position to judge whether there is clear evidence of blood contamination or consensual sexual activity with a peer, in which case they should be referring the young person to someone who can make that judgement. Hence, consider rather than suspect.
SH	RCPCH	91	Full	5	24	A possible definition or further detail on what FTT or faltering growth is should be included, as referrers are often unclear about this. Perhaps the inclusion of a pathway for referral for FTT would be useful.	Thank you. This has been added to the glossary. A pathway for referral is outside the scope of this guidance.
SH	RCPCH	92	Full	5.1	65 line 26-7	This may reflect a class bias and the outcome is the same for the child. However the final recommendation is fine. Perhaps it could be phrased better in text in relation to commentary.	Thank you for your comment.
SH	RCPCH	93	Full	5.1	67	The guideline should separate suspect and consider and place abandonment at the top	Thank you for this suggestion. We have been working with our editors to ensure the recommendations are presented in an appropriate order.
SH	RCPCH	94	Full	5.1	67	There was no meaning for the asterix in lines 11,14,17,19,21	Thank you for your comment. The asterisk was intended to represent recommendations derived from Delphi consensus but the explanation was removed accidentally. The layout of this section has been amended.
SH	RCPCH	95	Full	5.2	69	The recommendation in this section	Thank you for this comment. The GDG has

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						exemplifies the difficulties of defining specific features of neglect. Whilst this recommendation is appropriate, it is a simplistic approach which does not do justice to the complex issues which surround abnormal growth – first in defining abnormal growth in the first place, and second in appreciating the interplay of biological, developmental and ecological factors which impact on children's growth. There will be situations where a child has abnormal growth with no identifiable medical condition, but where there are no other concerning features and neglect can be readily discounted; conversely there may be situations where a child has a recognised medical condition contributing to abnormal growth, and yet neglect is also an important factor to be considered.	chosen 'consider' in this situation for the very reasons you state.
SH	RCPCH	96	Full	5.2	General	The emphasis on looking at any abnormal growth pattern rather than just failure to thrive is good.	Thank you.
SH	RCPCH	97	Full	5.3	69 line 27	This should be phrased as dental, not medical attention.	Thank you. This change has been made.
SH	RCPCH	98	Full	6	25-26	FII is the most difficult area of child maltreatment, and the guideline may benefit from further expansion of this section	Thank you for your comment. We have added a cross-reference to the RCPCH document on FII which discusses this in more detail.
SH	RCPCH	99	Full	6	Line 21	Healthcare professionals assessing infants with ALTE should carry out full ophthalmology examination, as the presence of retinal haemorrhages may indicate the need for further child protection investigations	Thank you for your comment. Examinations are outside the scope of this guidance. Thus we cannot make the suggested recommendation.
SH	RCPCH	100	Full	6	22	Should the term "NAHI" still be used? It has been dropped by the American Academy of	Thank you for your comment. There are many terms that are used for NAHI and it is always

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Paediatrics as not truly representing the injuries in question, and they are now stating that the term "inflicted head trauma" is the preferred one. As the majority of primary research evidence originates from the USA, it would seem appropriate to use similar terminology.	difficult to decide upon the most appropriate term. Any term chosen is often flawed as it suggests mechanism of injury or intent. Our understanding is that the Americans have settled upon AHT Abusive head trauma. We have deliberated on the topic and chosen to use the term 'inflicted head trauma' to represent a condition that is imposed upon the child by a second party. We have not used AHT as we are aware that the intent in some cases is not to abuse the child and secondly, this guidance sets out to identify suspicious cases of child maltreatment; the intent to harm is decided at the end point rather than the point of suspicion. The evidence that we used for the guidance referred to studies that addressed intracranial trauma, to distinguish from cases of head trauma that involved skull fracture or injury to the head that did not involve traumatic brain injury or injury to the structures around the brain but within the skull. The studies themselves used a number of different terms. In the recommendation we have used the term intra-cranial injury to reflect our topic of interest. In light of the comment we have revised the evidence section and our terminology with respect to NAHI which we agree is an outmoded term.
SH	RCPCH	101	Full	6	27	Section 29-39 should include 'except when the child had LD'	Thank you for this suggestion. The GDG believes that secondary wetting is not related to learning disabilities because the children have already gained continence in this

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							situation. The other presentations are under 'consider' which means that learning disabilities may be a suitable explanation for the presentation.
SH	RCPCH	102	Full	6.0	General	There is no mention of the FII in the early sections. I would suggest the FII section is moved above the separate sections on poisoning & ALTEs as there is overlap.	Thank you for this suggestion. We are working with our editors to ensure the flow is sensible.
SH	RCPCH	103	Full	6.3	73	On further reading nasal bleeding is mentioned in association with ALTE. Is there any evidence for nasal bleeding on its own?	Thank you for your comment. We identified no evidence on nasal bleeding on its own in relation to child maltreatment.
SH	RCPCH	104	Full	6.4	75	The evidence presented on ALTEs does not warrant the strength of the recommendation to suspect maltreatment with repeated presentations of ALTE – this should be considered maltreatment.	Thank you for your comment. The absence of empirical evidence does not preclude a 'suspect' recommendation. The GDG believes that repeated ALTEs can be dangerous and, as such, should warrant urgent action.
SH	RCPCH	105	Full	6.5	76	The guideline should to add in urine as well as blood levels	Thank you for pointing this out. Evidence of substances in the urine is covered by "biochemical evidence".
SH	RCPCH	106	Full	6.7	79	If the recommendations on page 79 were implemented by paediatric neurologists it is likely that fabricated or induced illness would be considered in a much larger number of children that is presently the case. Could replace the word 'consider' with 'suspect'	Thank you for your comment. The GDG believes this to be the case. The actions associated with considering maltreatment have been clarified to allow the professional to continue considering maltreatment, to suspect maltreatment or to rule out maltreatment.
SH	RCPCH	107	Full	6.7	General	Should be cross referenced to the RCPCH FII document	Thank you. A reference to this document has been added.
SH	RCPCH	108	Full	6.8	80	Given that parents are entitled to make alternative provision for education, including home education, it is inappropriate to consider maltreatment on grounds of poor school attendance. This should be amended to "consider child maltreatment if they become aware that a child is not receiving education	Thank you for these helpful suggestions. The recommendation now reads "consider child maltreatment if a child has poor school attendance that the parents or carers know about that has no justification on health, including mental health, grounds *and formally approved home education is not being*

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						with no justification on health, including mental health, grounds" or "consider child maltreatment if they become aware of poor school attendance that has no justification on health, including mental health, grounds and alternative arrangements for the child's education have not been made"	*provided*." We hope this change is helpful.
SH	RCPCH	109	Full	2 2.4	20 30-34	If the purpose of the document is to support initial clinical suspicion before a child has been referred to children's social care services or to a specialist child protection team, it is unhelpful to have the terms **consider** and **suspect** particularly if suspect equates to serious concern about the possibility of abuse or neglect. What to do about child abuse encourages us to refer a child if there is any concern. These definitions are confusing, unnecessary, unhelpful and conflict with existing documents such as The Physical Signs where no distinction exists. If you retain both terms then looking for indicators of maltreatment in the history, parent–child interaction or the child's presentation now or in the past, gathering information, discussion with senior colleagues and review should be part of suspected as well. Follow local guidance should apply to both consider as well as suspect.	Thank you for your comment. The terms consider and suspect have been operationally defined for this guidance. Comments from other stakeholders suggest that the terms are helpful and have been well understood in the context of the accompanying recommendations. It is true that local guidance should be followed at the 'consider' level but the GDG believes that such guidance is not specific enough for their purpose so has used this only in 'suspect'.
SH	RCPCH	110	Full	7	81-99	This emotional/behavioural section is very welcome as these issues are still largely unrecognised in the wider paediatric population and there is minimisation of the	Thank you.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						long term effects.	
SH	RCPCH	111	Full	7	101	The descriptions of sexualised behaviour and developmental norms are helpful	Thank you for your comment.
SH	RCPCH	112	Full	7.0	General	This section is welcomed and very useful.	Thank you for your comment.
SH	RCPCH	113	Full	7.2	94	There is no separate statement re prepubertal and younger children who self harm and evidence base included very few of this age. There should be more definite recommendations to highlight how uncommon it is to inform practitioners to carefully evaluate the possibility of abuse in this age group.	Thank you for this comment. The GDG believes that the inclusion of children as well as young people in the recommendation is sufficient.
SH	RCPCH	114	Full	7.2.10	104	The College would suggest that term "must" should be used when distinguishing between dissociation and day dreaming etc or otherwise the statement is very confusing. Specialist help will be needed to establish this difficult diagnosis."Must" therefore implies this is needed.	Thank you for highlighting this. We have amended this to 'is distinguished from'.
SH	RCPCH	115	Full	7.2.4		The recommendation to suspect rather than consider maltreatment in children who scavenge, steal hoard or hide food seems out of keeping with the lack of any evidence to support such a recommendation.	Thank you for your comment. The absence of empirical evidence does not preclude a 'suspect' recommendation.
SH	RCPCH	116	Full	7.2.8	101 line 26	The College is not sure why ASD is specifically mentioned here.	Thank you for your comment. Autistic spectrum disorder is mentioned here because there is a group of children with autistic spectrum disorder who display sexualised behaviours as part of their condition which may not be due to sexual abuse.
SH	RCPCH	117	Full	7.2.8	101 lines 27-9	The College is not clear about the meaning in relation to final half of sentence.	Thank you for your comment. The GDG agrees that clarification is required. The sentence has been amended to read:'….should not deter the young person

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							from seeking and receiving medical attention'.
SH	RCPCH	118	Full	7.2.9	103 line 12	Editing error - double full stop	Thank you for highlighting this. This typo has been corrected.
SH	RCPCH	119	Full	8	107	Although domestic abuse is mentioned here but it could still think be more prominent throughout the guideline.	Thank you for your comment. Domestic abuse is one of many indicators of maltreatment.
SH	RCPCH	120	Full	8.0	General	This section is welcomed and very useful.	Thank you for your comment.
SH	RCPCH	121	Full	General	33	The College is pleased with the suspect/ consider recommendation. However, we believe you should be more explicit about referral to social services rather than 'follow local guidance'. Health professionals are notorious for not referring to social services.	Thank you for this helpful suggestion. The third bullet point of 'suspect' now reads: "refer the child or young person to children's social care, following Local Safeguarding Children Board procedures" in the light of your comment.
SH	RCPCH	122	Full	General	6	Please thank the Child Protection Special Interest Group for their work on this guideline in the acknowledgements	Thank you for your comment. Neither the GDG nor the technical team has had any direct contact with the Child Protection Special Interest Group in the development of this guidance.
SH	RCPCH	123	Full	General	General	The document is comprehensive, easy to read and provides useful informative clinical features associated with child maltreatments. The latter are particularly relevant for the target professionals for whom dealing with possible child maltreatment is an infrequent occurrence. In this version we welcome the transparency of how consensus was reached amongst a diverse range of relevant professionals and as such represents an extremely important collation of views to produce this consensus guideline. It is clearly well referenced. Two final points are worth raising. First of all the Guideline must be read in conjunction with local safeguarding children guidelines and	Thank you commenting so extensively and positively on this draft In response to your final two questions, we would like to point out that the target audience for the guidance was discussed at the outset and the decision by our NICE commissioners was to restrict the target audience to health. However, we anticipate that the guidance will

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						procedures so therefore, we queried to what extent the guideline is owned by non health statutory partners such as social care services and police forces. The second point relates to the importance of frontline staff being equipped with easily accessible information in order to know who and where to contact in the event of a 'consideration' or 'suspicion' of child maltreatment.	be relevant to professionals outside health. We also agree with the second point and it is a question that relates to local implementation. We will pass your comment on to NICE's implementation team.
SH	RCPCH	124	Full	General	General	Overall an excellent document which compresses a great deal of information and advice.	Thank you for your support.
SH	RCPCH	125	Full	General	General	Very comprehensive guideline with appropriate conclusions drawn from literature. Problem is that is has the potential to be paralysing for inexperienced (and even experienced) paediatricians with such a massive list of when to suspect child maltreatment.	Thank you for your positive feedback. This guidance is an awareness-raising tool that comprehensively summarises many of the ways that maltreatment manifests itself. Shortening the list of indications would not support the assessment of children and would defeat the purpose of the guidance.
SH	RCPCH	126	Full	General	General	The guideline constitutes a very valuable summary of the available evidence and make very sensible recommendations and there are no criticisms form the orthopaedic standpoint.	Thank you.
SH	RCPCH	127	Full	General	General	This reflects a huge amount of work in collating available evidence on an important and controversial area of clinical practice. An overarching concern is the potential for an unmanageable increase in the number of child protection referrals and proceedings that it might generate, in a system already woefully overstretched in (probably) the majority of districts in the UK. What appears to be missing in the overall pathway is a step where the experienced	Thank you for raising this. The increase in referrals is outside the scope of the guideline that aims to support children rather than the system. The perceived absence of the involvement of a consultant paediatrician has been addressed in the options for 'consider' where one can talk to a senior colleague or a named or designated professional.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Consultant Paediatrician makes a balanced clinical judgement as to whether issues of child protection/safeguarding are pertinent to the individual case or not. If, at all levels, all cases where issues of child protection/safeguarding are to be discussed with the named/designated doctor, the latter will rapidly become overwhelmed and risk losing a holistic perspective. We need a system that ensures we always think carefully about the possibility of child maltreatment and refer the right children and young people onwards to more detailed and multiagency consideration, without creating so many meetings and proceedings to lose sight of those children most in need of safeguarding.	
SH	RCPCH	128	Full	General	General	The guideline is very useful but has been written in a way that assumes a level of familiarity/knowledge of maltreatment closer to that of a paediatric specialist, rather than its intended audience i.e., the non-paediatrician.	Thank you for your comment. Your concern has been noted but the response from other stakeholder groups does not indicate this to be the case.
SH	RCPCH	129	Full	General	General	The guideline gives well presented information but there is some doubt as to how this document is any different from the several publications from the RCPCH already available; if it is different the Guidance needs to say why and the reasons why this version should be used.	Thank you for your comments. The GDG were aware of all the RCPCH guidance and the development group included four paediatricians. Please note that the audience for this guidance is wide and the guidance has been developed to provide information for all health professionals.
SH	RCPCH	130	Full	General	General	The guideline should be more specific about domestic abuse. This is a type of maltreatment (within emotional abuse definition), not a risk factor. The guidelines are an opportunity to raise the profile of domestic abuse to health professionals. There must be evidence	Thank you for this comment. The GDG has emphasised in a recommendation that exposure to domestic abuse is part of the definition of emotional abuse. The GDG agrees that it is harmful to children and has acknowledged that in its recommendations.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						showing the damage it does to children. It is an indicator of emotional abuse and warrants referral to Social services in its own right.	
SH	RCPCH	131	Full	General	General	Can the evidence for nasal bleeding be ,more clearly defined?	Thank you. As you point out, nasal bleeding is addressed in Chapter 6.
SH	RCPCH	132	Full	General	General	CPSIG would be happy to help implement guidelines through conferences, website, newsletter, ebulletin, etc	Thank you for this offer. We will pass this on to the implementation team at NICE.
SH	RCPCH	133	Full	General	General	This guideline is an excellent piece of work and the review of literature is very helpful. As the GDG is well aware child abuse is a pattern/ picture/ jigsaw of clinical signs and presentations, and the problem with looking at each sign individually is that it feeds into the legal process of undermining individual signs. Could there be a comment either in forward/ introduction about this issue? The CSA guidelines did try and address this issue.	Thank you for this comment. The GDG would like to emphasise that individual signs can lead a health professional to suspect maltreatment; this would not obviate the possibility of the other indicators being present. Our operational definition of 'consider' fits more into the jigsaw paradigm to which you refer. 'Consider' indicators do not stand alone.
SH	RCPCH	134	Full	General	General	The College welcomes the categories of 'consider' and 'suspect'. The 'suspect' will allow /encourage professionals to act under the umbrella of the guidelines. The College also welcomes the wide range of conditions and presentations it covers – which may act as learning tool for some. The inclusion of so many indicators/behaviours should strengthen the safeguarding agenda in all areas of paediatric/young people's practice.	Thank you.
SH	RCPCH	135	Full	General	General	The glossary is not exhaustive and new terms are introduced within the document that should be defined e.g. laceration. Laceration should not be just confined to hymenal.	Thank you for highlighting this. 'Laceration' has been added to the glossary.
SH	RCPCH	136	Full	General	General	This is an excellent, painstakingly-detailed analysis of the literature which leads to a	Thank you. As you correctly state, training for health professionals is outside the scope of the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						clinically useful summary of child maltreatment. Our only negative comment (which we appreciate is outside the scope of the guideline but feel ought to be said anyway) is that to be effective a great deal of training will be required for those who do not see children everyday and for in the more subtle aspects e.g. emotional abuse, FII, for most practitioners.	guidance. We will pass your comment on to the implementation team at NICE who may have more input on this matter.
SH	RCPCH	137	Full	General	P20, line 18 P52 line 40 P 53, lines 3,4, 21 and probably more	The plural of 'frenulum' is 'frenula' and this is an incorrect anatomical term, the correct term is "renum" or "frena" for the plural.	Thank you for pointing this out. We are concerned that you read 'frenula' where we had written 'frena'. We will ensure that the correct terms appear in the final document.
SH	RCPCH	138	Full	General	General	With regard to the 'excluded studies' – would papers explaining 'how to diagnose' not be considered for guidelines on 'when to suspect' child maltreatment ?	Thank you for this comment. This guidance is not aimed at people making diagnoses of maltreatment, and diagnostic assessment, investigation and tests are specific exclusions from the scope; for these reasons those papers were excluded.
SH	RCPCH	139	Full	General	General	It is useful to read the recommendation for any particular topic then go to the evidence that supports it. This does usefully add to information on signs and symptoms. As pointed out in the document this is rather different from other NICE guidance. We hope the guideline will be used by practitioners as we am sure it will be helpful.	Thank you.
SH	RCPCH	140	Full	Glossar	12	There are some Inaccurate definitions of	Thank you. We have adopted the RCPCH

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				y		genital terms eg. Hymenal notch/ transaction/ posterior fourchette. These definitions should be in line with the RCPCH Physical Signs of Child Sexual Abuse handbook.	definitions where possible and acknowledged the RCPCH document. It should be noted that these two documents have different audiences so in some instances it is appropriate to use less technical language in the guideline.
SH	RCPCH	141	Full	Glossary	13 line 10	Neurological sequelae would be better defined as "consequences that manifest as neurological symptoms or signs". Consciousness is misspelt.	Thank you. These changes have been made.
SH	RCPCH	142	Full	3.1	33 Line 19	The document becomes more confusing when trying to interpret an alerting feature of child abuse and the actions you need to take in the paragraph that follows whilst we are asked to use the recommendations consider or suspect with similar actions.	Thank you for your comment. We have been working with the editorial team at NICE to ensure that the recommendations are usable.
SH	RCPCH	143	Full	General	P5	BPMHG is listed twice under stakeholder organisations nos. 35 & 36. The preferred name is no. 35.	This has been noted and corrected. Thank you.
SH	RCPCH	144	Both	General	General	Separating the NICE guidance and the full guideline means most practitioners will be drawn to a shorter version and read the statements out of context from the evidence and this may promote dangerous practice. All practitioners should only have the full copy and use the Summary of the recommendations if they need a quick guide.	Thank you for your comment. It is NICE's policy to publish the summary of recommendations in the NICE guideline.
SH	RCPCH	145	Both	General	General	If two documents are retained then abbreviations and glossary (definitions) should be also within the NICE version	Thank you for your comment. The developers have worked with the NICE editors to ensure that the NICE version contains explanations for the guidance-specific definitions and the terms within the recommendations. Within the NICE version all abbreviations are explained on first mention and abbreviations are used only where necessary. However, a full glossary is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							only available in the Full version.
SH	RCPCH	146	NICE	1	9	The guideline needs a section about those in health care who deal with adults and have child welfare concerns expressed to them: e.g. a woman (mother) admitted to adult ward in hospital and expresses concern about children left unsupervised with partner – what action should health care professional take? This issue should be discussed with Designated/Named person with child protection responsibility.	This is outside the scope of the guidance and the GDG refers you to Working Together.
SH	RCPCH	147	NICE	1.1.2	7	Where consideration means that maltreatment is a possible explanation, another point would be to make sure that differential diagnoses other than maltreatment are ruled out.	Thank you for this comment. The 'consider' definition has been amended and the following sentence now appears: "This may lead the healthcare professional to suspect child maltreatment, to exclude child maltreatment or to continue to consider child maltreatment." The actions that follow this sentence now apply only if maltreatment continues to be considered.
SH	RCPCH	148	NICE	1.1.2	8	The first sentence could it read as 'action is required if maltreatment is considered'	Indeed this is true, but the GDG believes the recommendation carries more weight as it is currently stated.
SH	RCPCH	149	NICE	1.1.2	8	In the second bullet point where the health professional is expected to gather collateral information form other disciplines within health and other agencies…is this always correct as it may be a task which is taken on by another designated professional and maybe we need to make this clear that he/she needs to follow the local safeguarding procedure.	Thank you for raising this. The task may be taken on by another professional but the person who initiates this is the person who considers maltreatment.
SH	RCPCH	150	NICE	1.1.2	8	Third bullet point - it may not be appropriate to wait and review as an action may be required straight away in order for the child to be safe	Thank you. This has been amended to: "ensure review of the child at a date appropriate to the concern…".

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	RCPCH	151	NICE	1.2.2	8	What about the concerns over a presentation being delayed?	Thank you for your comment. Delayed presentation is covered later in 'fail to promptly seek medical advice…'.
SH	RCPCH	152	NICE	1.2.2 onwards		There is considerable repetition e.g. each sentence starts with Healthcare professionals should. This could be stated at the start of the para and then omitted in each sentence.	Thank you for your comment. NICE recently adopted an editorial style in which all recommendations are directive and all recommendations have been changed to start with a verb.
SH	RCPCH	153	NICE	1.2.4	9	This section needs more clarity as to what is safe and what isn't safe cultural practice within our safeguarding policies	Thank you for your comment. The GDG's view is that mentioning specific (and self-evidently) harmful practices has the potential to detract from the general message.
SH	RCPCH	154	NICE	1.3	10	1.3 – this should include 'no explanation' for bruising and with last bullet point add ear bruising and over spine? No explanation should also be included in sections 1.3.5, 1.3.7.1.3.11, 1.5	Thank you for this suggestion. We have included ear in the list in the last bullet point as it seems an important omission. We feel that spine is covered under "bruises other than on bony prominences". It is not possible to add 'no explanation' here as many innocent bruises do not have an explanation. We have used 'absent' explanation where we feel it to be appropriate.
SH	RCPCH	155	NICE	1.3.12	13	The term 'extra axial bleeds' should be explained as a non-specialist may not be familiar with this term.	Thank you. This term has been removed.
SH	RCPCH	156	NICE	1.3.2	10	The term 'uniform bruising' should be explained.	Thank you for your comment. We have removed 'uniform' and replaced it with 'similar shape and size' as this is a better description.
SH	RCPCH	157	NICE	1.3.6		We should use the correct medical term and define it e.g. cut should be laceration.	Thank you for the comment. We have changed 'cut' to 'laceration (cut)' because the audience of this guidance is wider than doctors.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	RCPCH	158	NICE	1.3.7	12	An explanation should be included as to *why* scalds with symmetry or sharp borders imply forced immersion.	Thank you for this suggestion. We would hope that readers refer back to the evidence cited for this type of information. We have had to limit the material that we can provide in the documents. Had we provided an explanation as to why every indicator implies maltreatment the document would have become something of a text book, which is beyond the scope of the guidance. We hope that the guidance will be used in conjunction with other key documents and educational material.
SH	RCPCH	159	NICE	1.4.7	18	One sentence states " that neglect occurs if the child's medical needs are not met". This is a very significant problem in paediatric practice and there should be more emphasis on this. It would be more appropriate to state "if the child's medical leads are not met partly or fully and they are suffering or at risk of suffering significant harm then that neglect or in the case of significant harm child abuse should be suspected". I feel that this is a topic that should have a separate entry in the guidelines under the topic of "neglect of medical needs". Consideration could then be given on further guidance as to exactly at which point neglect occurs and then crosses over to child abuse.	Thank you for your comment. Discussion of 'thresholds' is outside the scope of this guideline.
SH	RCPCH	160	NICE	1.5.3	20	For ALTE, the College suggests the wording should be changed from '….where the onset is witnessed only by the carer..' to 'where the onset is witnessed only by one carer…'; or, leave the wording same but cross reference to para's 1.5.8-10 where this is covered.	Thank you. This change has been made.
SH	RCPCH	161	NICE	1.5.3	20	'ALTE' is well known to paediatricians but not	Thank you for your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						to non-specialists.	
SH	RCPCH	162	NICE	1.5.5	20	The second bullet point should be reworded '…unexpected blood levels of prescribed or non-prescribed medication….' There have been reported cases of deliberate poisoning using prescribed medication (anti-convulsant) ultimately proven by blood drug levels.	Thank you for highlighting this. We have changed this to: "there are unexpected blood levels of drugs not prescribed for the child."
SH	RCPCH	163	NICE	1.5.6	20	This should be reworded to '….consider child maltreatment in cases of hypernatramia …' (not hypernatraemic dehydration: the dehydration bit is irrelevant).	Thank you for this suggestion. This change has been made.
SH	RCPCH	164	NICE	1.5.9	21	This whole section represents reasons to 'suspect' FII: for many of the bullet points that follow, the actions to take on 'suspect' (section 1.1.1 which includes 'follow local procedures (on) child being abused..') is likely to be excessive. To do this, for instance, when there isn't the expected response to treatment can be excessive. This whole section should be changed to '..to consider..' child abuse.	Thank you for this comment which highlights the lack of clarity in the originally proposed 'suspect' recommendation. The GDG had intended that the 'suspect' recommendation depended on the 'consider' recommendation being met. We have been working with the editorial team at NICE to ensure clarity in this section.
SH	RCPCH	165	NICE	1.6.19	26	This paragraph regarding 'dissociation' is confusing so perhaps the non-paediatrician will be equally perplexed.	Thank you. This statement has been amended to ensure clarity.
SH	RCPCH	166	NICE	1.6.6	24	As every general paediatrician knows non-specific RAP is very common in secondary care and even more so in the community; is there really robust evidence of a substantial association with maltreatment?	Thank you for your comment. The GDG has now removed this recommendation and made a research recommendation.
SH	RCPCH	167	NICE	1.6.9	24	Selective mutism is well known to paediatricians but not to non-specialists.	Thank you. We appreciate your concern and the recommendation has now been removed.
SH	RCPCH	168	NICE	General	General	The document is easy to read and clear with regard to the explanations given for the guidance –specific definitions.	Thank you.
SH	RCPCH	169	NICE	General	Gener	It would be beneficial to separate out "suspect"	Thank you for your comment. We have been

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					al	and "consider " in each section.	working with the NICE editors to establish a usable format for the recommendations.
SH	RCPCH	170	NICE	General	General	The comments for the full guidance will apply to the NICE guidance	Thank you for your comment.This has been noted and the comments addressed in relation to the NICE and full guidelines, where appropriate.
SH	RCPCH	171	Full	General	General	The guideline should be sent to the American Association of Paediatrics and selected Child Protection experts in the US as there is increasing use of American Child protection experts in cases in the UK.	Thank you for this suggestion. We will pass it on to the implementation team at NICE, which is responsible for disseminating the guidance.
SH	Royal College of General Practitioners	1	General			The Primary Care Child Safeguarding Forum is pleased to be able to respond to the production of NICE Guidance on Child Maltreatment in England. The PCCSF is a UK-wide organisation, affiliated to the Royal College of General Practitioners, which represents Doctors who work within the NHS to Safeguard Children and Young People. Most of our members are General Practitioners, and many have extended roles with Primary Care Trusts/LCCSBs/Health Boards, or Healthcare Workforce Deaneries, working both with healthcare professionals and with NHS bodies to train the workforce in recognition of Child Maltreatment. We welcome the production of guidance on Safeguarding Children in Primary Care, and particularly this guidance for professionals on recognising Child Maltreatment. Not only will it be of use to General Practitioners and their	Thank you for commenting on this draft.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						teams, but to Out of Hours providers, Sexual Health Clinics, Accident & Emergency Departments, NHS Walk-in Centres, and Private Hospitals and Clinics. We are concerned that organisations like ourselves, with no administrative structure, are disadvantaged by being compelled to use a proforma to respond. We are concerned that you may take less cognisance of feedback which is valid, but not correctly formatted.	
SH	Royal College of General Practitioners	2	Guidance Overview			We are mindful that the scope of this document is actually to target and inform all healthcare professionals: in the introduction to the NICE guideline draft, and in section 1.2 of the full guidance, reference is made to "healthcare professionals who are not specialists in child protection … to support initial clinical suspicion before a child has been referred to children's social care services or to a specialist child protection team". We are concerned that this may lead the uninformed reader to conclude that these guidelines are mainly intended to apply to professionals working in primary care, and we are sure this is not your intent. We feel that the use of the term "specialist" is unhelpful here in both senses. You may be unaware of the existence of practice, federation or community-based child protection or safeguarding teams. In the modern NHS, there is much less of a divide between primary and secondary care, with primary care taking on much of what were	Thank you for your comments. It is our intention that the guidance be applicable to all health professionals working with children and young people, as you suggest. The scope of the guideline states that a specialist is a named or designated professional or a professional who is recognised to be a specialist in the field of maltreatment, and this is not related to seniority or sector. The actions associated with 'consider' and 'suspect' have been further clarified. We agree that the topic numbering may be confusing. This is tied in with different editorial styles and we will work with the NICE editors to ensure clarity in the final versions of all the guideline documents.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						once considered to be "specialist" roles. Our suggestion is that the guidance should be expressly applicable to all professionals working with children and young people, regardless of context. We also have some concern that professionals may confuse the terms "consider" and "suspect", despite the effort you have made to clarify what is meant. These are not terms used currently in this way in everyday General Practice. Other alternatives which you may wish to consider include "Traffic Light" [also known as RAG] systems, currently widely used in suspected cancer guidance, back pain assessment, and prescribing schemes, where Red Flags equate to strong suspicion, Amber might equate to moderate suspicion [where you now have "suspect], and Green equate to "Consider". For consistency of style, it would be better to start in each section with "suspect" indicators, and then "consider" [see 1.5.8 in NICE Guideline for example]. This leads on to our final general concern, that you have different topic numbering in the "Full" guidance from the "NICE" guidance. The complex arrangements you have had to make to receive feedback provide evidence of the confusing impact this will have on teams who try to adopt these. It might be better to use lettering/numbering of sections, rather than just numbering.	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Royal College of General Practitioners	3	Full	general	general	We don't feel that "Consider" and "Suspect" are terms GPs and their teams are currently familiar with: consider traffic light system instead [see above]	Thank you for this suggestion. GPs and their teams may not yet be familiar with these carefully devised operational definitions of 'consider' and 'suspect' but the GDG hopes that the associated actions are clear and that the definitions will confront some of the barriers to the recognition of child maltreatment. A traffic light system would also need defining specifically for this guidance.
SH	Royal College of General Practitioners	4	Full	general	general	If using "Suspect" and "Consider", there needs to be consistency in one coming before the other: in several instances, they are jumbled. There is also omission of the "no action is not an option" concept from "suspect".	Thank you for your comment. We have been working with the NICE editors to ensure that the recommendations appear in a logical and consistent order. The GDG believes that "no action is not an option" is implicit in the instructions that accompany 'suspect'.
SH	Royal College of General Practitioners	5	Full	general	general	We recognise that health professionals currently have difficulty crossing thresholds set by partner agencies, such as police and social care services. Redefining the levels of our concern about children runs the risk, if done in isolation from partner agencies, of exacerbating this existing problem.	Thank you for your comment. The GDG notes your concern and will pass it on to the implementation team at NICE who are in contact with other agencies.
SH	Royal College of General Practitioners	6	Full	general	general	When trying to describe physical features, picture evidence may be much more effective than word descriptions. "Ligature marks", "Facial Petechiae" [NICE 1.5.2 p19], "injury to the teeth, gums, tongue, frena or oral cavity" [NICE 1.3. p17] provide examples where pictures may be more informative.	Thank you for your comment. This is a good suggestion but NICE's editorial policy does prevents us from using pictures in recommendations.
SH	Royal	7	Full	1.2	14	We are mindful that the scope of this	Thank you for your comments. It is our

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	College of General Practitioners					document is actually to target and inform all healthcare professionals: in the introduction to the NICE guideline draft, and in section 1.2 of the full guidance, reference is made to "healthcare professionals who are not specialists in child protection … to support initial clinical suspicion before a child has been referred to children's social care services or to a specialist child protection team". We are concerned that this may lead the uninformed reader to conclude that these guidelines are mainly intended to apply to professionals working in primary care, and we are sure this is not your intent. We feel that the use of the term "specialist" is unhelpful here in both senses. You may be unaware of the existence of practice, federation or community-based child protection or safeguarding teams. In the modern NHS, there is much less of a divide between primary and secondary care, with primary care taking on much of what were once considered to be "specialist" roles. Our suggestion is that the guidance should be expressly applicable to all professionals working with children and young people, regardless of context.	intention that the guidance be applicable to all health professionals working with children and young people, as you suggest. The scope of the guideline states that a specialist is a named or designated professional or a professional who is recognised to be a specialist in the field of maltreatment, and this is not related to seniority or sector.
SH	Royal College of General Practitioners	8	Full	1.3	15	There is an inconsistency between p15, and pp32-33: the guidance excludes consideration of risk factors, but then sets out a useful table of risk factors in section 3. To be useful to frontline workers, any guidance document produced should include these to help guide understanding. A document for front line	Thank you. Risk factors need to be highlighted but of themselves are not necessarily indicators that a child has been maltreated. They are not, as you say, part of the actual guidance. We hope we have struck a balance within the remit we have been given.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						workers should be small, easy to read and useful and be clear about its flaws.	
SH	Royal College of General Practitioners	9	NICE	1.1.2	7	Professionals may also review notes of parents/carers/siblings to look for other markers of neglect or "hidden harm". This guidance has the opportunity to highlight the importance and usefulness of the continuing GP record, exclusive to the NHS in the UK.	Thank you for this suggestion. . We support information sharing but across the NHS there are restrictions on information sharing that would prevent such a recommendation being practical.
SH	Royal College of General Practitioners	10	NICE	1.2.9	9	If not going to reproduce definitions here, at least refer back to p4/5 for full definitions. Is the bullet list a full list of WTog supplements?	Thank you. The definitions appear in the full version (chapter 3) and in the NICE guidance. The recommendation about using the definitions has been removed.
SH	Royal College of General Practitioners	11	NICE Full	1.3.10/11 4.1.7	12 46	Fractures: firstly, "suspect" should come first [see above]. Some of our members questioned the placement of fractures with no traumatic cause in the "consider" category. We cannot see how evidence has led to this conclusion, rather than the corollary.	Thank you for your comment. This section has been reviewed and amended in accordance with several similar suggestions from other stakeholders.
SH	Royal College of General Practitioners	12	NICE	1.3.15	14	We understood that investigations [skeletal survey, MRI] were outside the scope of the guidance. If they are to be included, there is inference that they should be performed by the people for whom this guidance is intended.	Thank you for this comment. The GDG is not recommending that such investigations are conducted, rather that if a person conducting such an investigation comes across an indicator of maltreatment as a result of this presentation, they should follow the appropriate guidance.
SH	Royal College of General Practitioners	13	NICE	1.3.18	15	The link between sexual abuse and inappropriately sexualised behaviour is slightly lost by placing it further back in the 1.6 "emotional dysfunction" section. Even if left there, would it not be helpful to have mention/reference in this section [1.3.18-31]? Some professionals may focus on physical signs and believe these more important?	Thank you for this comment. The GDG chose to focus on indicators as they present rather than the type of abuse that causes them.
SH	Royal	14	NICE	1.3.28	17	Definition of consensual might be helpful: it will	Thank you. We agree that establishing

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	College of General Practitioners			[same with 1.3.31]		be difficult for professionals to interpret that. We will then need NMC/GMC clarification of what this means.	whether sexual activity is consensual is complex. However, the GDG believes it is necessary for the professional to establish this. How to do this falls outside the scope of this guidance. The recommendations that the GDG have made where it is necessary to establish whether sexual activity has been consensual are all 'consider' recommendations. This means that health professionals are alerted to the need to seek advice from experienced peers who would be able to help establish whether sexual activity was consensual.
SH	Royal College of General Practitioners	15	Full	5.1	64	The paragraph on conceptualisation of neglect acknowledges the importance and difficulty of identification and recommendations, including the one on abnormal growth patterns, are helpful.	Thank you for your comment.
SH	Royal College of General Practitioners	16	NICE	1.4.5	18	We recommend placing this first, as the most evident presentation of neglect in primary care. It may be helpful to include specifics: • failure to attend 6-8 week check • failure to attend immunisation appointments • failure to attend chronic disease clinics e.g. asthma	Thank you for this suggestion. The GDG preferred to keep this as a more general recommendation.
SH	Royal College of General Practitioners	17	NICE	1.4.14	19	We have some reservations about the strength of the evidence used to link obesity and abuse. We think there is a danger of syllogism; that while maltreatment may cause obesity, it is not shown that all obese children are victims of abuse, and no consideration is given to the autonomy of the child or young person in this consideration. There is a risk that	Thank you for your comment. The recommendation has been removed.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						professionals may cite this recommendation to justify their own prejudices.	
SH	Royal College of General Practitioners	18	NICE	1.5.6	20	How is hypernatraemic dehydration diagnosed without investigations [Scope Exclusion 1.3]? The inference is that professionals should somehow be able to differentiate between types of dehydration on primary clinical assessment: this is not appropriate in primary care.	Thank you for your comment. This has been changed to 'hypernatraemia'. This guidance is directed at all healthcare professionals so a hospital paediatrician / laboratory staff could well be the first to identify a very high sodium level.
SH	Royal College of General Practitioners	19	Full	6	71-80	This is a useful chapter with recommendations on fabricated and induced illness which will be helpful for non specialists	Thank you.
SH	Royal College of General Practitioners	20	NICE	1.5.10	22	Within multiprofessional Practice Child Protection Teams, we find school attendance to be an extremely reliable and useful indicator: perhaps it needs to be raised in its profile?	The GDG welcomes this comment but is restricted to commenting on school attendance within the context of health.
SH	Royal College of General Practitioners	21	NICE	1.6.4	23	We are worried that NSPCC findings [Cawson et al 2000] might suggest a figure as high as 2.4 million children regularly shouldering adult responsibilities: services need to be in place to meet this need.	Thank you for your comment. We agree with your concern but service organisation is outside the scope of the guidance.
SH	Royal College of General Practitioners	22	NICE	1.6.8	24	Some expansion of what is meant by "medical causes", and its inclusion in the Glossary, would be helpful.	Thank you for your comment. 'Medical causes' here refers to bulimia and autistic spectrum disorders. This has been added to the GDG considerations.
SH	Royal College of Midwives	1	Full	General	14	The Royal College of midwives is pleased to comment on this important document. The document clearly assists with identifying the possible indicators of maltreatment, this will be a useful reference for practitioners	Thank you for your comment.
SH	Royal	2	Full	1.2	14	The guidance provides a clear summary of	Thank you for your comment. The GDG

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	College of Midwives					clinical feature associated with maltreatment and will raise awareness of factors to observe for when providing care. However, **how the document can be used to support practice is not clear**, as the guidance doesn't address risk factors.	believes that the document can be used despite the absence of discussion about risk factors because, as you state, it raises awareness of clinical indicators that a health professional may observe. You may like to submit a theme for future NICE guidance. (http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp)
SH	Royal College of Midwives	3	Full	1.3	15	Areas outside scope will affect the utility of the document. E.g. Given the exclusions of the document, i.e risk factors for maltreatment – professionals are not provided with an opportunity to intervene before harm occurs. The document should support professional and parents in reducing the incidence of harm before it occurs. There needs to be direction to practitioners on how they should talk to parents about challenging behaviours. **Protection of the unborn is a significant exclusion – as often where there is a history of abuse, families need further support or intervention to protect the health of the future child.** Maltreatment should be considered in the wider context and should not be seen in isolation as maltreatment has multiple indicators. i.e social factors and context	Thank you for your comment. Communication with parents is outside the scope of the guidance, as are social factors. The GDG agrees that social indicators are important in the identification of maltreatment and suggests that you submit this as a theme for future NICE guidance. (http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp)
SH	Royal College of Midwives	4	Full	1.4	15	The guidance on who the consultation is for – it needs to specifically mention midwives to ensure that midwives engage with the document	Thank you for this suggestion. Midwives are included in "professional groups who are routinely involved in the care of children and families". The implementation team at NICE

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
							will work to ensure that all relevant groups are reached.
SH	Royal College of Midwives	5	Full	2.4	31	In recording concerns and/or suspicion there needs to be clarity of where the information is recorded. How will professionals be supported to ensure that the relationships remain therapeutic where concerns are raised? Should ContactPoint be the vehicle to ensure that records are stored and shared appropriately?	Thank you for your comment. The GDG has amended the recommendation about recording observations so that it specifies the child's/young person's clinical record. ContactPoint has not been rolled out yet, the GDG is therefore unable to note it as a reference point at this stage.
SH	Royal College of Nursing	1	All	General	General	The RCN supports and welcomes this guideline. It is very comprehensive and covers the subject very clearly.	Thank you.
SH	Royal College of Nursing	2	NICE	General	General	Use of word 'should' in this guideline - is this strong enough? We would suggest the word 'MUST' particularly for some of the recommendations!	Thank you for your comment. The words "healthcare professionals should" have been removed from recommendations in line with NICE's editorial policy. This same policy does not permit us to use the word 'must' but we hope that removing 'healthcare professionals should …' will encourage them to act.
SH	Royal College of Nursing	3	NICE	Emotional abuse	4	Emotional abuse: Not sure about the word 'convey'. It makes it seem like the child knows what is going on when emotional abuse can be very subtle and the child just feels like they are not part of the family, very unloved and unwanted but may not realise what is going on.	Thank you for your comment. The cited definitions are those found in Working Together. The GDG has chosen not to change any wording in order to support inter-agency working.
SH	Royal College of Nursing	4	NICE	Intro/Communication	6	Information Sharing should be much stronger and specific (could it link to specific professional guidance such as Information Guidance: Practitioner's guide HM Gov 2006).	Thank you for this suggestion. The information sharing pocket guide has been added to the list of relevant documents cited in the full guideline.
SH	Royal College of Nursing	5	NICE	Communication	6	Communication: Where it mentions about keeping confidentiality - think this should say that it is	Thank you for your comment. The specific matter of communicating with children about suspicions is outside the scope of this

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						best practice to raise this issue with the child or young person before the disclosure so they understand fully. Also it is important to mention somewhere in the document that once a child / young person has disclosed then they will be kept as safe as possible and hopefully not put back into the home to suffer more abuse.	guidance.
SH	Royal College of Nursing	6	NICE	8	1.1.2	It is not up to us all (healthcare professionals) to believe or decide if the child is being maltreated. It should be highlighted that we are not the investigators but should show that we believe/suspect maltreatment.	Thank you for your comment. It is for this reason that the GDG has provided operational definitions of 'consider' and 'suspect'.
SH	Royal College of Nursing	7	NICE	1.11	7	There is advice about recording but it is important that healthcare professionals not only observe and record but act on their observations and this did not come across in the document.	Thank you for your comment. The GDG has clarified the action by stating "refer the child to children's social care, following your Local Safeguarding Children Board procedures."
SH	Royal College of Nursing	8	NICE	1.2.2	8	No mention of delayed presentation	Thank you for your comment. Delayed presentation is covered later in 'fail to promptly seek medical advice…'.
SH	Royal College of Nursing	9	NICE	1.2.4	9	Child Maltreatment is never cultural – this should be made clear in the guideline	Thank you. This statement has been amended to ensure clarity.
SH	Royal College of Nursing	10	NICE	1.2.5	9	Not sure what this means?	Thank you. This statement has been amended to ensure clarity.
SH	Royal College of Nursing	11	NICE	1.2.6	9	Disabled children are more likely to be abused than non disabled children.	Thank you for your comment. Disability in children has been added to the list of risk factors for maltreatment.
SH	Royal College of Nursing	12	NICE	1.2.8	9	Need to be more specific about safeguarding supervision and support for staff.	Thank you for your comment. Unfortunately, training for staff and service organisation is outside the scope of this guidance.
SH	Royal College of	13	NICE	1.2.9	10	Suggest to be much more specific that domestic abuse within a household is	Thank you. Domestic violence is discussed in chapter 8.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Nursing					detrimental to children	
SH	Royal College of Nursing	14	NICE	1.3.2	10	Need to be very specific that any non mobile baby with an unexplained mark or injury must have a paediatric assessment.	Thank you**.** We agree with this point and that is why we have given non-mobile babies as a specific example.
SH	Royal College of Nursing	15	NICE	1.3.2	10	Last bullet point - No mention of ears: feel they should be included	Thank you for this suggestion. We have included ear in the list in the last bullet point as it seems an important omission.
SH	Royal College of Nursing	16	NICE	1.3.9	12	Hair loss – it should be noted that there are many causes: neglect, poor diet, eczema, infestation etc	Thank you for this comment. We believe the complete guidance reflects this. Three out of four of the causes that you list should elicit a consideration of maltreatment and are covered in later recommendations.
SH	Royal College of Nursing	17	NICE	1.3.10	12	Need to explain how rare brittle bone is (evidence)	Thank you for this suggestion. It is not possible for us to look for and cite evidence of the prevalence of other causative factors of the indicators of maltreatment, although we agree that in some instances such information would be helpful.
SH	Royal College of Nursing	18	NICE	1.3.19/20	15	Duplication of information	Thank you for your comment. The context is different for these two recommendations so it is not possible to combine them.
SH	Royal College of Nursing	19	NICE	1.5.8	21	Fabricated or induced illness (FII) cases should always involve the designated Doctor as they (FII) are always very complex and stressful.	Thank you. This is covered in the operational definitions of consider and suspect.
SH	Royal College of Nursing	20	NICE	General	General	There is nothing about over familiarity of child who is being abused.	Thank you for your comment. In the recommendation about interpersonal behaviours, the GDG cites "over-friendliness towards strangers".
SH	Royal College of Speech and Language Therapists	1	Full	7.2.5	97	*"The GDG believes that the possibility of maltreatment as a precursor for selective mutism needs to be considered."* Contrary to your belief, "there is no basis from	Thank you very much for this comment. The GDG acknowledges this was an area where we have been able to consider the issue afresh as a result of your comments and the recommendation has been removed.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						the available evidence for treating selective mutism as a probable indicator that a child has been abused." Reference: page 45, Cline, T. and Baldwin, S. (2004). *Selective Mutism in Children.* London: Whurr. "While early trauma and family problems have been suggested as possible contributing factors by some mental health professionals, they've been largely dismissed as primary causes in the development of selective mutism." "According to more systematic studies, children with selective mutism are not more likely than other children to have a history of early trauma or stressful life events (for example, Steinhausen and Juzi 1996)." "Although there have been some case reports suggesting a link between family dysfunction and selective mutism, evidence from well-designed research studies does not support this relationship (Kristensen 2000), (Cunningham et al, 2004), (Vecchio and Kearney 2005)." References: pages 31-33, Angela McHolm, Ph. D., Charles Cunningham, Ph.D., and Melanie Vanier, MA, 2005, *Helping Your Child With Selective Mutism*, Raincoast Books. Steinhausen H and Juzi C. 1996. *Elective*	Furthermore the definition and the text have been revised to acknowledge that selective mutism is probably an anxiety disorder and it is different from traumatic mutism.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Mutism: An analysis of 100 cases. Journal of the American Academy of Child and Adolescent Psychiatry. Kristensen, H. 2000. *Selective Mutism and comorbidity with developmental disorder/delay, anxiety disorder and elimination disorder*. Journal of the American Academy of Child and Adolescent Psychiatry, 39, 249-256. Cunningham, C.E., Mc Holm, A., Boyle M.H. & Patel, S, 2004. *Behavioural and emotional adjustment, family functioning, academic performance and social relationships in children with selective mutism.* Journal of Child Psychology and Psychiatry, 45 (8), 1363-1372. Vecchio J.L., and Kearney, C.A. 2005. *Selective Mutism in Children: comparison to youths with and without anxiety disorders,* Journal of Psychopathology and Behavioural Assessment, 27(1), 31-37. "Although there have been occasional reports of selective mutism following an early hospitalization or trauma, evaluations of the patients in our clinic have not suggested that selective mutism is caused by trauma. Certainly, a careful history should be taken, but parents of selectively mute children should not be assumed to be abusing their children. Parents have related stories about how mental health and school systems have confronted them about 'presumed abuse'. These	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						unfortunate accusations appear to stem from the paucity of available information and the misunderstandings about selective mutism in both the general and the psychiatric communities." Reference: page 288, Freeman, J.B., Garcia, A.M., Miller, L.M., Dow, S.P. and Leonard, H.L. (2004). Selective Mutism. In J.S. March and T.L. Morris (Eds) *Anxiety Disorders in Children and Adolescents* (2nd Edition). New York: Guilford Publications. We should ***always*** be on the alert for maltreatment but to suggest that we should be ***more*** alert with selectively mute children than with autistic or dyslexic or learning disabled children, for example, will send clinicians down the wrong path, cause untold and unnecessary distress to parents and ***delay appropriate treatment***. Early intervention is essential (Keen et al, 2008) (Johnson and Wintgens, 2001) and we cannot afford to lose families at the first hurdle through inappropriate suspicions and questioning. References: Selective Mutism: A consensus based care pathway of good practice *Arch. Dis. Child.* published online 2 May 2008; Daphne Keen, Sarita Joan Fonseca and Alison Wintgens. Johnson M & Wintgens A, 2001, *The Selective*	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Mutism Resource Manual, Speechmark Publishing Ltd, Bicester.	
SH	Royal College of Speech and Language Therapists	2	Full	7.2.5	97	Rather than being related to maltreatment, "selective mutism is now acknowledged as an anxiety condition (which) appears to lie on a spectrum between shyness and severe social phobia." Reference: Selective Mutism: A consensus based care pathway of good practice *Arch. Dis. Child.* published online 2 May 2008; Daphne Keen, Sarita Joan Fonseca and Alison Wintgens. Thirteen recognised experts from North America, Europe and Australia contributed to this care pathway by participating in a modified Delphi process involving two rounds using a Likert-scale and free commentary. Both quantitative and qualitative analyses were used in the validation or revision of the statements at each stage. These experts concluded that "Consistent with approaches to other anxiety disorders, behavioural and cognitive behavioural therapies seem effective". There was no suggestion that children suffering from selective mutism require counselling or other interventions aimed at dealing with the effects of abuse or maltreatment. It is recognised that assessment may reveal additional emotional factors requiring additional specialist interventions, but such factors are rarely found	Thank you very much for this comment. The GDG acknowledges this was an area where we have been able to consider the issue afresh as a result of your comments and the recommendation has been removed. Furthermore the definition and the text have been revised to acknowledge that selective mutism is probably an anxiety disorder and it is different from traumatic mutism.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						and not central to a diagnosis of selective mutism.	
SH	Royal College of Speech and Language Therapists	3	Full	7.2.5	97	Your definition of selective mutism is out of date. DSM IV (1994) changed the diagnostic criteria for selective mutism from 'Consistent refusal…' to 'Consistent ***failure*** to speak in specific social situations (in which there is an expectation for speaking, e.g. at school) despite speaking in other situations.' It was at this time that the term 'elective mutism' was changed to 'selective mutism' in recognition that it was not the child's ***choice*** to withhold speech. Rather they were rendered unable to speak as a result of anxiety when outside their comfort zone. In contrast with maltreated children, it is recognised that selectively mute children are least anxious and most verbal in familiar settings such as their home environment. Reference: Cunningham, C.E., Mc Holm, A., Boyle M.H. & Patel, S, 2004. *Behavioural and emotional adjustment, family functioning, academic performance and social relationships in children with selective mutism.* Journal of Child Psychology and Psychiatry, 45 (8), 1363-1372. Selective mutism is an internationally recognised condition which carries a clinical diagnosis. There is mounting evidence that SM is a symptom (or variant) of social phobia.	The definition and the text have been revised. Kindly see response to your above comment (comment number 2) for further details.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						There is no suggestion in literature that social phobia is caused by maltreatment in the home, any more than any other anxiety disorder. Main causes of social phobia seem to be: Genetic disposition, developmental stage and chemical imbalance. References: Kristensen H., (2001) *Personality Traits and Symptom Traits in Parents of Children With Selective Mutism: A Case-Control Study Journal of Abnormal Psychology*, 2001, Vol. 110, No. 4, 648-652 Sharp W., Sherman C & Gross A., (2007) *Selective mutism and anxiety: A review of the current conceptualization of the disorder,* Journal of Anxiety Disorders Volume 21, Issue 4, pages 568-579 Steinhausen H. et al (2006), *A long-term outcome study of selective mutism in childhood*, Journal of Child Psychology and Psychiatry 47:7, pp 751–756	
SH	Royal College of Speech and Language Therapists	4	Full	7.2.5	97	Selective mutism is on the increase and no longer as rare as previously believed. A recent survey arrived at a prevalence of 0.71%, which is about the same as published prevalence rates for childhood obsessive-compulsive disorder and higher than published rates of autism. The 125 teachers surveyed were responsible for 2,256 children, and 16 of the children met the DSM-IV criteria for selective	Kindly see response to your above comment (comment number 2).

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						mutism. Reference: Bergman, Piacentini, & McCracken, 2002. *Prevalence and description of selective mutism in a school-based sample*, J. Am. Acad. Child Adolesc. Psychiatry 41[8]:938-46. However, there is another type of mutism which IS extremely rare. I believe you are confusing selective mutism with 'traumatic mutism'. While cases of mutism have occurred as a result of a child being abused or emotionally or physically traumatized, it seems to be very rare. In recent systematic studies no selectively mute children were found to have a history of speaking normally until a traumatic incident. References: Black B. Uhde TW. *Psychiatric characteristics of children with selective mutism: a pilot study.* Journal of the American Academy of Child & Adolescent Psychiatry. 34(7):847-56, Jul 1995. Dummit ES 3rd. Klein RG. Tancer NK. Asche B. Martin J. Fairbanks JA. *Systematic assessment of 50 children with selective mutism*. Journal of the American Academy of Child & Adolescent Psychiatry. 36(5):653-60, May1997. In 31 years of practice I have come across	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						hundreds of children with selective mutism and only one case where a child spoke normally until traumatic domestic upheaval and then stopped speaking to almost everyone. However, I have known several 'late onset' selectively mute children who had indeed been maltreated – ***but this was always in the form of bullying from teachers or peers.*** If the draft NICE guidelines had specified 'maltreatment in the form of bullying, peer pressure or unsympathetic teaching' I would not be contesting them, but left open, I firmly believe that the reference to maltreatment is going to be interpreted as maltreatment in the home. All the evidence indicates that it would be best to remove the reference to selective mutism altogether, and replace it with 'traumatic mutism'. A report in 1980 by Hayden described "traumatic mutism" as a subgroup of cases reported in a chart review study, but in the paper it is stated that where police or social service reports could be found to document child abuse, the reports always indicated that a child was abused because they were not speaking, not the other way around. Reference: Hayden TL (1980), Classification of elective mutism. J Am Acad Child. Psychiatry 19:118-133 Nonetheless we certainly cannot rule out the	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						possibility of traumatic mutism and if children withdraw communication suddenly (not the usual pattern with ***selective*** mutism) the possibility of shock or maltreatment (either from within or outside the home) should certainly be considered. Please note that it is the sudden withdrawal of communication that is important, not a difficulty or disinterest in engaging itself – this point needs to be made in order to exclude children with genuine but undiagnosed communication difficulties, e.g. those on the autistic spectrum.	
SH	Royal National Orthopaedic Hospital NHS Trust	1	Full	1.1	14	please omit the sentence in brackets. The change in nomenclature from CP register to CP plan is petty, and not worth highlighting in the opening paragraph of such a major work. If it has to remain at least say 'subject to a CPP' rather than 'subject of'.	Thank you for your comment. The data have been updated to 2008 figures so no reference is made to the child protection register. The wording "subject of" appears in Every Child Matters; the GDG wishes to retain this form of words.
SH	Royal National Orthopaedic Hospital NHS Trust	2	Full	Appendix A	108	Omit. These are not "Declarations of Interest" in the usual sense (potential conflicts of interest). They are authors' qualifications, relevant experience, and publications they are proud of! You could call the appendix "brief biographies" or "résumés". If you mean Declarations of Interest then give such things as fees received from campaigning groups or representing parties in legal disputes etc...	Thank you. We have made modifications to the presentation of this information where required. However, the extensive nature of the interests declared is also attributable to the NCC-WCH's implementation of the NICE policy which requests both personal pecuniary and non-pecuniary as well as non-personal pecuniary and non-pecuniary interests to be declared. Advice received from NICE has been to err towards over-declaring interests to avoid any material conflicts of interest being undeclared.
SH	Royal National Orthopaedic Hospital NHS	3	Full	2.1	24	Poor wording: "pregnancy constitutes maltreatment". Pregnancy implies or indicates, it does NOT constitute abuse.	Thank you for these suggestions. This text has been changed to "means".

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust						
SH	Royal National Orthopaedic Hospital NHS Trust	4	Full	4.2	63	Ditto - Poor wording: "pregnancy constitutes maltreatment". Pregnancy implies or indicates, it does NOT constitute abuse.	Thank you for these suggestions. This text has been changed to "imeans".
SH	Selective Mutism Information and Research Association	1	Full	7.2.5	97	An examinations of evidence on the suggested association between selective mutism and child maltreatment needs to go beyond the single study that is cited in the draft guidance that has been circulated for consultation. That study is flawed (see below), and other studies do not corroborate the link highlighted in the draft guidance. This is shown in the following extract from Cline and Baldwin (2004, pp. 44 - 45). Cline, T. and Baldwin, S. (2004). *Selective Mutism in Children.* London: Whurr. "In extreme cases the pattern of selective mutism has sometimes appeared to be associated with child abuse - a little-understood association that requires further research (Adams and Glasner, 1954; Hayden, 1980, p. 125; Hayden, 1983). Great care is required in interpreting material in this field. There have been isolated case reports in which a selectively mute child is shown to have had a history of physical or sex abuse (e.g. Jacobsen, 1995). But some commentary which has highlighted the issue has cited case reports in which a child was related to a victim	Thank you very much for this comment and the level of detail provided. The GDG acknowledges this was an area where we have been able to consider the issue afresh as result of your comment and the recommendation has been removed. However, we cannot include these studies in the evidence base since they are either text books or do not meet our selection criteria.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						of violence but had not themselves been a direct victim (e.g. Maskey, 2001 citing Szabo, 1996). If claims of an association are taken at their face value, it could lead to professionals believing that selective mutism should be taken as a possible symptom of abuse so that a referral of the former should lead to an investigation to check for the latter (Leonard and Topol, 1993). The basis for that judgement might be findings such as that of Black and Uhde (1995) who observed that parents of four of the thirty selectively mute children whom they studied (13%) reported a history of physical or sexual abuse. They commented, however: Two of these subjects had onset of SM before suffering a single incident of sexual abuse by a non-family member. Another child suffered chronic mild abuse and neglect by his mother from age 2 until she abandoned the family when he was 4½ years old. He was subsequently well cared for by his father. Age of onset of SM was unclear, but it was at approximately age 4 or 5. one boy was briefly mistreated by his father at 18 months of age. The father was sent to prison for sexually abusing an older sister shortly thereafter. There was no clear temporal or causal relationship between the onset of SM and the abuse in any case. (pp. 851-852)	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						In a larger survey involving 153 families Ford et al. (1998) found that 2% identified physical abuse as a precipitating cause of selective mutism and 1.3% identified sexual abuse. McGregor, Pullar and Cundall (1994) carried out a retrospective case-control study of children identified by schools as selectively mute in one English city. They examined school medical records, the child protection database held by community paediatric departments and the child protection register held by the social services department. They found evidence of definite or probable abuse in 8 out of 18 case records relating to children with selective mutism compared with only one amongst two groups of controls. There are methodological reasons for treating the data with caution: children identified as selectively mute may have been more likely than controls to be investigated for possible family abuse, and head teachers' recall of ex-pupils with selective mutism may have been more vivid in cases where an additional factor such as suspected abuse had played a part in the history. The authors confidently drew the conclusion that 'many types of traumatic experience may precipitate elective mutism, but it is likely that child abuse, particularly child sexual abuse, is a causal factor in some subjects' (p. 541). However, further studies are required to support that conclusion when other group studies have yielded such different findings. The question of a possible	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						association between experience of abuse and the development of selective mutism remains open. Neither clinical reports nor survey data have yet satisfactorily resolved it. There is no basis from the available evidence for treating selective mutism as a probable indicator that a child has been abused." **References** Adams, H. and Glasner, P. (1954). Emotional involvements in some forms of mutism. *Journal of Speech and Hearing Disorders*, 19, 59 - 69. Black, B., & Uhde, T. W. (1995). Psychiatric characteristics of children with selective mutism: A pilot study. Journal of the American Academy of Child and Adolescent Psychiatry, 34(7), 847– 856. Ford, M., Sladeczek, I., Carlson, J. and Kratochwill, T.R. (1998). Selective mutism: phenomenological characteristics. *School Psychology Quarterly*, 13, (3), 192 - 227. Hayden, T. L. (1980). Classification of elective mutism. Journal of the American Academy of Child and Adolescent Psychiatry, 19, 118–133. Hayden, T. L. (1983). *Murphy's Boy*. London: Gollancz.	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Jacobsen, T. (1995). Case study: is selective mutism a manifestation of dissociative identity disorder? *Journal of the American Academy of Child and Adolescent Psychiatry,* 34, (7), 863 - 866. Leonard, H.L. and Topol, D.A. (1993). Elective mutism. *Child and Adolescent Psychiatric Clinics of America,* 2, (4), 695 - 707. Maskey, S. (2001). Selective mutism, social phobia and moclobemide: a case report. *Clinical Child Psychology and Psychiatry,* 6, (3), 363 - 369. McGregor, R., Pullar, A. and Cundall, D. (1994). Silent in school - elective mutism and abuse. *Archives of Disease in Childhood*, 70, (6), 540 - 541. Szabo, C.P. (1996). Selective mutism and social anxiety. *Journal of the American Academy of Child and Adolescent Psychiatry,* 35, (5), 555. The need for caution was also recognized in a major North American textbook on anxiety disorders: Extract from Freeman et al (2004, p. 288) Freeman, J.B., Garcia, A.M., Miller, L.M., Dow, S.P. and Leonard, H.L. (2004). Selective	

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Mutism. In J.S. March and T.L. Morris (Eds) *Anxiety Disorders in Children and Adolescents* (2nd Edition). New York: Guilford Publications. "Although there have been occasional reports of selective mutism following an early hospitalization or trauma, evaluations of the patients in our clinic have not suggested that selective mutism is caused by trauma. Certainly, a careful history should be taken, but parents of selectively mute children should not be assumed to be abusing their children. Parents have related stories about how mental health and school systems have confronted them about "presumed abuse." These unfortunate accusations appear to stem from the paucity of available information and the misunderstandings about selective mutism in both the general and the psychiatric communities."	
SH	Social Care Institute for Excellence (SCIE)	1	NICE	Introduction	3	First paragraph very helpful in unequivocal statement about focus on initial suspicion before referral suggest delete 'it is unusual that' suggest 'the guidance is **here** to raise awareness ' suggest sentence commencing 'physical abuse can be fatal' should be stated first in the paragraph	Thank you for your comment. The introduction has been revised following consultation.
SH	Social Care	2	NICE	Introduc	5	'Maternal substance abuse'. This is the only	Thank you for your comment. The reference

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Institute for Excellence (SCIE)			tion		reference in whole doc about a complex issue including: the relationship between drug misuse and parental neglect or active harming; legal status of foetus; clinical consequences on foetus of maternal compliance with opiate detoxification or drug maintenance regime (i.e. baby born in withdrawal) as distinct from intentional neglect. Suggest removing reference or giving more attention to topic within guideline and linking to NICE guideline in development: 'social complications of pregnancy'. suggest statement to effect that children may be at risk of any or several forms of maltreatment at the same time	has only been included as part of the definition of neglect used. However, maltreatment of unborn children is a specific exclusion from the scope of this guidance and therefore we are unable to address this issue.
SH	Social Care Institute for Excellence (SCIE)	3	NICE	Introduction	6	'When they are unable to maintain confidentiality' is ambiguous. Suggest 'about the limits to confidentiality' and link to DCSF Guidance 2008 on Information Sharing http://www.everychildmatters.gov.uk/resources-and-practice/IG00340/	Thank you for this suggestion. The information sharing pocket guide has been added to the list of relevant documents cited in the full guideline.
SH	Social Care Institute for Excellence (SCIE)	4	NICE	1.1.1	7	Suggest 'record exactly what they see and hear **from whom and when'**	Thank you for this suggestion. It has been adopted.
SH	Social Care Institute for Excellence (SCIE)	5	NICE	1.2.2.	8/9	Suggest 'professionals should **always** suspect maltreatment if they …	Thank you for your comment. The NICE editorial style is now such that recommendations start with a verb. This now reads 'Suspect…'
SH	Social Care Institute for Excellence (SCIE)	6	NICE	1.2.5	9	This is a helpful expectation Suggest 'should understand that' instead of be aware that the Phrase 'health care professionals' is unnecessarily repeated?	Thank you. We have been working with the editorial team at NICE to ensure clarity in this section.
SH	Social Care	7	NICE	1.3	10-27	Police child protection officers are very	Thank you for your comment. This document is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Institute for Excellence (SCIE)			-1.7		experienced in identification child maltreatment and could usefully be involved in review and implementation of this section, if not already	primarily for use in the NHS but we will forward this comment to the implementation team at NICE in case they are involving other agencies.
SH	Social Care Institute for Excellence (SCIE)	8	NICE	1.3.27	16	Under 16s might be in a coercive relationship with a peer as more clearly set out in 1.3.28	Thank you. We agree that, by definition, consensual relationships are not coercive.
SH	Social Care Institute for Excellence (SCIE)	9	NICE	1.3.29	17	Very helpful to have this section	Thank you.
SH	Social Care Institute for Excellence (SCIE)	10	NICE	1.5.10		This is a helpful expectation	Thank you. For information, the recommendation now reads "consider child maltreatment if a child has poor school attendance that the parents or carers know about that has no justification on health, including mental health, grounds *and formally approved home education is not being provided*." in response to comments from other stakeholders.
SH	Social Care Institute for Excellence (SCIE)	11	NICE	1.6.4	23	For information-the concept of care taking roles is disputed particularly by the disabled parents' lobby, however SCIE considers that this is important and needs to be included here –the point is well made about age-inappropriate responsibilities	Thank you for this information.
SH	Social Care Institute for Excellence (SCIE)	12	NICE	General	General	The pitch, tone and scope of this document eloquently addresses some of the major problems in inter-professional working, that is, anxiety about professional boundaries and responsibilities. It sets these clearly within accepted professional activity and expertise	Thank you for your comments.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						and helps practitioners to understand their specific expert contribution	
SH	Sussex Partnership NHS Foundation trust	1	NICE	General	General	The areas of maltreatment covered are useful and comprehensive. The recommendations that flow from each of these areas seem to have a well examined evidence base and they will, we believe, provide a helpful set of pointers for practitioners to follow should they suspect maltreatment in any of the areas identified.	Thank you for commenting on this draft and for your support.
SH	Sussex Partnership NHS Foundation trust	2	NICE	General	General	Useful guidelines. Can be used to understand risk profiles of children. For example, if a child (younger than 18) self harms, then we need to use an age appropriate risk assessment tool that could also reflect the guidelines.	Thank you for your comment.
SH	Sussex Partnership NHS Foundation trust	3	NICE	General	General	There is no mention in the guidance that abuse is not class specific. Many professionals continue to be shocked when child abuse cases occur with middle class articulate parents. Could this be included?	Thank you for raising this. A sentence to this effect has been added to the introduction.
SH	Sussex Partnership NHS Foundation trust	4	NICE	Physical and emotional abuse	e 4	Showing signs of overfeeding could come under physical and emotional harm	Thank you for your comment. The definitions set out on page 4 of the NICE version are taken from 'Working Together to Safeguard Children (2006).
SH	Sussex Partnership NHS Foundation trust	5	NICE	Communicating	Page 6	Communication needs to also take into account the professional using age appropriate language to the child or young person without patronising.	Thank you for your comment. This is implicit under 'good communication' and is expected of all health professionals regardless of context.
SH	Sussex Partnership NHS Foundation	6	NICE	1.2.2	Page 9	If disclosure occurs the professional should receive the information without asking too many questions about the detail as this can be seen to contaminate evidence.	Thank you for your comment. How to proceed once maltreatment is suspected is outside the scope of this guidance so we cannot make recommendations in this respect.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	trust						
SH	Sussex Partnership NHS Foundation trust	7	NICE	1.2.4	Page 9	It may be worth naming some of the harmful cultural practices	Thank you for this suggestion. The GDG's view is that mentioning specific (and self-evidently) harmful practices has the potential to detract from the general message.
SH	Sussex Partnership NHS Foundation trust	8	NICE	1.2.6	Page 9	Professionals need to make themselves aware of specialist workers they can call on	Thank you for your comment. This is outside the scope of the guidance but may be considered by the implementation team at NICE.
SH	Sussex Partnership NHS Foundation trust	9	NICE	1.3.1	Page 10	May wish to add Finger Mark, as children also have been known to have finger poke/ prod marks on their bodies	Thank you for this suggestion. The GDG believes that this type of mark would be picked up under the current definition so has chosen not to add it.
SH	Sussex Partnership NHS Foundation trust	10	NICE	1.3.18	Page 15	Should consider physical and or sexual	Thank you for your comment. The GDG believes these are mostly related to sexual abuse.
SH	Sussex Partnership NHS Foundation trust	11	NICE	1.7	Page 26	Could include parents, especially first time parents being over organised, e.g., nothing out of place in the home, over cleanliness, overly neat child and no sign of mess on the child or around the home	Thank you for your comment. This is a risk factor and as such outside the scope of this guidance.
SH	Sussex Partnership NHS Foundation trust	12	NICE	1.1.1	Page 7	Omit serious and just have concern.	Thank you for your comment. The difference between consider and suspect is the difference between concern and serious concern. We have now placed the definition of consider before that of suspect to illustrate that distinction.
SH	Taunton & Somerset	1	NICE	General	General	The style of the document is very repetitive & tedious. If you want a non-specialist to read	Thank you for your comment. We have been working with the editorial team at NICE on the

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	NHS Foundation Trust					this (and clearly this is who this document is aimed at) then it must be short & snappy with bullet points of key symptoms & signs. Diagrams would be helpful as would tables to break up the prose. Improved focus would target the attention of the non-specialist who would be much more likely to read a more concise but informative document	production of a Quick Reference Guide which will contain a summary of the recommendations.
SH	Taunton & Somerset NHS Foundation Trust	2	NICE	General	General	Distinguishing between concern & suspect adds unnecessary confusion and is very subjective. If someone has considered abuse then it should be excluded confidently (probably by referring to someone who has the relevant expertise)	Thank you for your comment. The 'consider' definition has been amended and the following sentence now appears: "This may lead the healthcare professional to suspect child maltreatment, to exclude child maltreatment or to continue to consider child maltreatment." The actions that follow this sentence now only apply if maltreatment continues to be considered. We hope this is helpful.
SH	Taunton & Somerset NHS Foundation Trust	3	NICE	Algorithm	38	The algorithm is extremely confusing and not user friendly	Thank you for your comment. Amendments have been made to the algorithm in order to make it clearer and more user friendly.
SH	The Association of Directors of Children's Services (ADCS)	1	Full	1.1	14	Doesn't mention the Children Act 2004, safeguarding rather than child protection and talks about social services rather than children's services. It doesn't reflect the current statutory base or the systems and processes outside the clinician's room. More context is also needed i.e. the last paragraph of section 1.1 would be a good place to add some context on inter-agency work rather than just reference it briefly as here.	Thank you for your comment. Safeguarding is wider than maltreatment and includes the wider prevention of harm to children. This is not within the scope of this guideline.
SH	The	2	Full	1.2	14	No reference to DCSF or safeguarding.	Thank you for your comment. Reference is

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Association of Directors of Children's Services (ADCS)					Doesn't place this guidance in the multi-agency framework or reflect current practises.	made to the need for interagency cooperation and communication under both 'suspect' and 'consider' and in the 'how to use this guidance' section.
SH	The Association of Directors of Children's Services (ADCS)	3	Full	1.3	15	Areas outside the scope of the guidance –lines 12 and 13 - it explicitly says that "how healthcare professionals should proceed once they have come to suspect maltreatment" and "child protection procedures" are out of scope. A footnote that says where the guidance is on these two vital topics would be very helpful.	Thank you for your comment. Our operational definition of 'suspect' now points readers to LSCB guidance.
SH	The Association of Directors of Children's Services (ADCS)	4	Full	1.4	15	For whom is the guidance intended? Unclear – who are "professional groups routinely involved in the care of children and families"?	Thank you for your comment. This guidance is intended for health professionals and the GDG would welcome its acceptance by other agencies.
SH	The Association of Directors of Children's Services (ADCS)	5	Full	1.5	15	Who has developed the guidance? – This is not as multi-agency as it needs to be.	Thank you for your comment. This guidance has been developed for use by health professionals so the GDG has been developed by a group of relevant people within health.
SH	The Association of Directors of Children's Services (ADCS)	6	Full	1.6	16	Other relevant documents – doesn't include all the Change for Children – health guidance 2004	Thank you for this suggestion. The document you cite is about service organisation, which is outside the scope of this guidance, so we will not be directing readers to it.
SH	The Association of Directors of Children's	7	Full	2.1	20	Needs to link to safeguarding multi-agency practise; Lines 24 and 25 - potentially this would be a place to reference the Common Assessment Framework as useful in gathering	Thank you for your comment. The Common Asssessment Framework is beyond the scope of this guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Services (ADCS)					and collating information about a child and family about whom there are concerns/need for intervention but not Child protection intervention; Lines 40 and 41 - the guidance could be fuller here by either referencing the relevant guidance i.e. What to do if and Working Together.	
SH	The Association of Directors of Children's Services (ADCS)	8	Full	2.1	24	"Healthcare professionals must recognise that sexual intercourse in a child aged under 13 years is unlawful and therefore pregnancy constitutes maltreatment" – this is unlawful and dangerous. Under 16s? Rape?	Thank you for your comment. The GDG believes that it has addressed the legal issues around consent in this area appropriately.
SH	The Association of Directors of Children's Services (ADCS)	9	Full	General	General	Overall the guidance does the job it is designed to do, which is quite narrow, but it would be greatly helped by a bit more context, which is where the references to inter-agency work and related procedures and guidance such as to Working Together and related guidance and to Common Assessment Framework could be located along with the references to where the guidance can be found.	Thank you for your comment. Reference is made to the need for interagency cooperation and communication under both 'suspect' and 'consider' and in the 'how to use this guidance' section.
SH	The Association of Educational Psychologists	1	Full	2		**Aim of the guidance** The first bullet point would better read "raising awareness of the clinical and behavioural features associated with maltreatment and the possibility of it."	Thank you for this comment. The sentence you mention is contained in the scope for the guideline which cannot be changed.
SH	The Association of	2	Full	3		**Target audience** Although the main users of the guidance will be healthcare professionals, but we believe	Thank you for your suggestion. Educational psychologists are covered under 'professionals working in…education settings'.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Educational Psychologists					that it is appropriate to refer to other professionals and suggest the addition of 'and other professionals such as educational psychologists'.	
SH	The Association of Educational Psychologists	3	Full	5		**Definitions** In this section,, Specialists in child protection' are named and designated healthcare professionals. We believe that it is appropriate to refer to other professionals and suggest the addition 'but may include other professionals such as educational psychologists'.	Thank you for your comment. The term 'specialist' has been defined for the purpose of this guidance as stated. This is as set out in the scope and therefore cannot be changed.
SH	The Association of Educational Psychologists	4	Full	6		**Clinical questions** The Association would welcome the opportunity to be included in the consultation and would be happy to nominate a member to represent it.	Thank you for commenting on this draft.
SH	The Association of Educational Psychologists	5	Full	General		We believe that the guidance would be strengthened by statement within a preamble that acknowledges at the outset the fundamental principles of children and young peoples' rights to be free from abuse, neglect, exploitation, as enshrined in the UN Convention.. This would ndorse a wholisistic view of the child. The AEP would be pleased to advise further on this.	Thank you for your suggestion. The following sentence has been added to the introduction: "This guidance is predicated on an acceptance of the paramountcy of the needs of children as articulated in the United Nations Convention on the Rights of the Child, specifically article 19."
SH	The Association of Educational	6	Full	General		It is customary to use the terms children and young people, not just children and especially as the guidance relates to children and young people up to the age of 18 years	Thank you for highlighting this. This has been addressed in the revised recommendations.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Psychologists						
SH	The Association of Educational Psychologists	7	Full	General		The AEP does not feel the guidance contains enough information regarding multiple abuses. It is the experience of our members that more than one type of abuse are experienced at the same time by children and young people.	Thank you for your comment. The function of the guidance is not to identify types of maltreatment but to raise awareness of the possibility of maltreatment through clinical indicators. The GDG recognises that multiple abuses occur and our definition of 'consider' includes looking for other indicators.
SH	The Association of Educational Psychologists	8	Full	General		The AEP would like to see a greater focus on children and young people with additional needs or disabilities and the impact on them, e.g. their communication.	Thank you for your comment, Matters of communication with children, including children with disabilities, are addressed in the NICE version.
SH	The Association of Educational Psychologists	9	Full	General		We believe that here needs to be more awareness of the importance of ethnicity factors and cultural backgrounds in this area. Educational psychologists are well placed to advise schools or other professionals on this matter.	Thank you for your comment. The following sentence has been added to the methodology section of the guidance, 'In accordance with NICE's Equality Scheme, ethnic and cultural considerations and factors relating to disabilities have been considered by the GDG throughout the development process and specifically addressed in individual recommendations where relevant'. With regards to advising schools and other professionals, this is outside the scope of the guidance.
SH	The Association of Educational Psychologist	10	Full	General		We feel it is is a serious omission not to mention educational psychologists in the "Developing Group". There is one mention of "child psychologist", however this ignores the important role that educational psychologists	Thank you for your comment. This guidance has been developed for use by health professionals so the GDG has been developed by a group of relevant people within health. We value your comments as registered

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	s					may play. For example, educational psychologists are more likely to come across children and young people for whom maltreatment is suspected who have not been referred to health services than most other professionals.	stakeholders for the guideline.
SH	The Association of Educational Psychologists	11	Full	General		We believe that there should be greater emphasis on the psychological and emotional indicators of abuse and neglect. We would be pleased to advise further on this	Thank you for this suggestion and your offer of help. The GDG, which includes a psychiatrist and a psychologist, has addressed the psychological and emotional indicators that it deems relevant to health professionals during initial presentation to health professionals.
SH	The Association of Educational Psychologists	12	Full	General		There appears to be no reference to children and young people who are themselves perpetrators of sexual abuse against others. Research evidence indicates that children and young people who abuse are also themselves subject to abuse or have been historically abused.	Thank you for raising this. Perpetrators of sexual abuse are alluded to in two recommendations that refer to coercive and indiscriminate sexual behaviour.
SH	The Welsh Ambulance Service NHS Trust	1	NICE	General	General	Overall excellent guidance which reflects accurately the type of Child protection referrals/concerns we currently identify and refer on. Very comprehensive and extremely well written overall. A few comments are included to contribute constructively to this consultation.	Thank you for commenting on this draft guidance.
SH	The Welsh Ambulance Service NHS Trust	2	NICE	General	General	I appreciate this is not a guidance document on what procedures to follow, however there should be at least brief reference made to the following important considerations in order to tie into 'best practice' and point the way	Thank you for your comment.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						forward once a .	
SH	The Welsh Ambulance Service NHS Trust	3	NICE	General	General	Concern that the word 'consent' is not used once even if to refer the reader on to find further guidance and advice regarding when to seek consent for information sharing or enquiry between agencies.	Thank you for raising this. The recommendation about communicating with other agencies has been amended to: "gather collateral information from other disciplines within health and other agencies, having used professional judgement about whether to explain to the child, young person and/or parent/carer your need to gather this information because of the need for an overall assessment of the child." The guidance does not recommend interventions and therefore the GDG believes that the question of seeking consent for interventions does not arise.
SH	The Welsh Ambulance Service NHS Trust	4	NICE	General	General	No mention of Forced Marriage or forcibly taking a child out of the country for such purposes	Thank you for your comment. These issues are not within the scope of the guideline (which focuses on health care indicators of maltreatment).
SH	The Welsh Ambulance Service NHS Trust	5	NICE	General	General	The Rights of the Child are not referenced or acknowledged although the section on communicating with the child does contain some suggestion, I think this should be clarified even if to state that these are important but should not jeopardise a referral.	Thank you for highlighting this. Reference has now been made in the introductory text to the UN convention of the rights of the child.
SH	The Welsh Ambulance Service NHS Trust	6	NICE	Introduction	3	A short sentence acknowledging that identification of maltreatment may occur either through case work, individual one off direct contact, third party information or telephone assessments such as NHS Direct may be useful.	Thank you for this suggestion. We are keen to maintain a concise and succinct introduction so, although we agree with your point, we will not be including it.
SH	The Welsh Ambulance Service NHS	7	NICE	Communicating with the	6	This section appears to be trying to accomplish too much and it may be better to have extra separate headings. It does not reference	Thank you for your comment. This is standard NICE text about communicating with children. The specific matter of communicating with

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust			child or Young Person		Fraser guidelines or any of the above considerations such as Children Rights or Consent. Importantly it references an English document but does not mention the Welsh version which is different. Also no mention is made when NOT to communicate with Parents/Carers or when it would not be safe to do so.	parents is outside the scope of this guidance. The reference to English statutory guidance has been removed.
SH	The Welsh Ambulance Service NHS Trust	8	NICE	Appendix C The algorithm	38	Again no mention acknowledgement reminder or clarification of consent issues (where appropriate) regarding 'gather collateral information from other disciplines within health and other agencies'.	Thank you for raising this. The recommendation about communicating with other agencies has been amended to: "gather collateral information from other disciplines within health and other agencies, having used professional judgement about whether to explain to the child, young person and/or parent/carer your need to gather this information because of the need for an overall assessment of the child." The guidance does not recommend interventions and therefore the GDG believes that the question of seeking consent for interventions does not arise.
SH	The Welsh Ambulance Service NHS Trust	9	NICE	1.1.1	7	Concern that there is no reference to National Child Protection Procedures (as opposed to local) in the case of Wales.	Thank you for raising this. This instruction has been changed to: "refer the child to children's social care, following Local Safeguarding Children Board procedures."
SH	The Welsh Ambulance Service NHS Trust	10	Full	1.1	14 (Line 3 & 7)	No Welsh references to Child Protection Register stats .	Thank you for pointing this out. Data for year end March 2008 have been added.
SH	The Welsh Ambulance Service NHS	11	Full	1.1	14 (line 25 & 26)	Only the English document is referenced	Thank you for pointing this out. The definitions adopted by the GDG are those contained in the English document; since the definitions in

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust						the Welsh document are different we cite only the English document in this particular instance.
SH	The Young ME Sufferers Trust		Full	6.7	79	We wish to alert NICE to the frequency of erroneous Child Protection measures being taken against families whose children have ME/CFS (myalgic encephalomyelitis/chronic fatigue syndrome). A warning should be included in the NICE Guideline on suspected abuse to the disproportionate frequency with which this is happening. The Young ME Sufferers Trust made a presentation (by invitation) in 2008 to the All Party Parliamentary Group on ME, indicating that children suffering with ME/CFS (Myalgic Encephalomelitis / Chronic Fatigue Syndrome), which is the commonest cause of long term sickness absence from school, are disproportionately at risk of erroneous child protection procedings. Statistics were presented to the APPG. Here is a link to the presentation: www.tymestrust.org/pdfs/childprotectionissues.pdf We have made the following two recommendations, which are in the record of the presentation: ACTION 1.The Trust takes the view that The Department of Children Schools and Families should urgently alert Social Services professionals to the frequency of misunderstandings in cases of ME.	Thank you for your comments. They have been noted.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						2.The Trust also recommends that a leaflet clarifying the procedures that should be adhered to by professionals in child protection investigations should be given to families under suspicion, and they should be informed of their rights. Apart from our recommendations on this paragraph, we also wish to be associated with, and support, the general comments on this NICE Guideline by Dr Lynne Wrennall, Coordinator, Public Health Research Group.	
SH	Triangle	1	NICE		6	'Inability to speak or read English' should include where English is the second language	Thank you for your comment. However, the GDG felt that this distinction was not appropriate as just because English is your second language, it does not automatically mean that you will be unable to read or speak the language.
SH	Triangle	2	NICE	1.2.6		'Maltreatment in children with disabilities may be more difficult to recognise ' this should be a much stronger statement about the increased vulnerability of disabled children to all kinds of abuse, and give more enabling guidance to professionalls	Thank you. Disability in children has been added to the list of risk factors.
SH	Triangle	3	Appendices	general		We are concerned that the considerable research base on the increased vulnerability of disabled children is not cited as we think this is an essential source of information in terms of when to suspect child maltreatment	Thank you for highlighting this. Despite the research evidence on disability as a risk factor for maltreatment, there is little research on the indicators of abuse in disabled children. Disability has been added to the list of risk factors for maltreatment in chapter 3.
SH	Triangle	4	NICE	general		Summary information about special measures, especially the use of intermediaries in the criminal justice system, should be referenced in the section on communicating with children	Thank you for this suggestion. It is outside the scope of the guidance.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Unite Health Sector	1	Full	34	17	The search strategy appears to be extremely extensive and thus gives the highest possible potential for encouraging the use of evidence based practice in practice.	Thank you for this observation and for commenting on this draft guidance.
SH	Unite Health Sector	2	Full	2.1	20	These are very clear statements of recommended actions. However, many practitioners including community practitioners (e.g. health visitors, school nurses) in practice have to deal with the suspicions of others. It is important that the document includes recommendations about how these practitioners must deal with these suspicions. Currently the section only refers to an individual's suspicion of maltreatment.	Thank you for your comment. This is outside the scope of the guidance and the GDG refers you to Working Together.
SH	Unite Health Sector	3	Full	2.1.24	20	This sentence/recommendation implies the need to investigate suspicions of maltreatment. However this is not in the remit of many community practitioners e.g. health visitors and school nurses. It is important that these recommendations acknowledge the important contribution that health visitors and school nurses make with the detailed, holistic assessment that they undertake. It is also important to acknowledge that rather than having a remit in investigation the school nurse and health visitor has an important role to play in referral and liaison with the clients as well as the other professionals.	Thank you for your comment. This guidance is not about investigation. It is about recognition and initial action.
SH	Unite Health Sector	4	Full	2.1.25	20	The recommendation is to 'review the child at a later date'. However, Unite/CPHVA would suggest that this statement must be more prescriptive and offer suggested time scales for review which are considered by the evidence to be appropriate and that would	Thank you for this suggestion. We have changed the wording to read "ensure review of the child or young person at a *date appropriate to the concern,* looking out for repeated presentations of this or any other alerting feature." We feel that we cannot be more

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						proffer safe practice. This is important especially in many professional groups including health visiting and school nursing where increasingly complex activity is being delegated to practitioners with varying levels of skills and knowledge in this field of practice. These professional groups are also working within organisations that dictate the frequency of contact to clients and restrict their ability to be proactive, reactive, and flexible to individual client need. Timescales will promote consistent action and service delivery.	prescriptive than this because the length of time depends on a number of factors. We hope this change is helpful, however.
SH	Unite Health Sector	5	full	2.1.40	20	It is important to make the distinction between investigating a situation and collection information during assessment of a situation. For example, some practitioners, like school nurses and health visitors are involved in safe guarding and contribute to the process by undertaking an holistic assessment; the results of which they pass on to other members of the multi professional team for investigation. It is also important to include reference to the need to maintain communication and collaboration within the multi professional / agency team and the importance of effective liaison between professionals in different professions.	Thank you for your comment. This guidance is not about investigation. It is about recognition and initial action.
SH	Unite Health Sector	6	Full	2.1.36	20	The recommendation states that 'the healthcare professional should…' it is important that the expectation of this activity is clear to the practitioners reading the final document. Unite/ CPHVA would suggest that this sentence must include the word 'MUST' rather than should which may imply that the health professional can make the choice of	Thank you for your comment. The recommendation has been reworded to enphasise the action to be taken. However, the term 'must' is not used in NICE recommendations, except where statutory guidance/legislation is being reiterated

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						whether or not to do this.	
SH	Unite Health Sector	7	Full	2.1.1,2, 3	21	It is important that the recommendations include reference to the elements of collusion and outline ways in which practitioners must take steps to avoid involvement in collusion.	Thank you. This point is addressed in the obstacles to recognising maltreatment.
SH	Unite Health Sector	8	Full	General	general	The document refers to 'healthcare professionals'. Where this is commendable in many situations in the document and enhances the transferability of the information to the many professionals involved in safeguarding, it may provide too much scope of individual interpretation and failure to take responsibility for actions at specific stages. Unite/CPHVA would suggest that the recommendations are supplemented with examples of health care professionals who will be involved at specific stages and an outline of the expected outcomes for that involvement.	Thank you for this suggestion. The guidance applies to all health professionals. It acts as a prompt to non specialists to inform critical thinking and in some circumstances clinical suspicion. These considerations should not detract from professionals' responsibilities towards children.
SH	Unite Health Sector	9	Full	3.1.42	34	The section must include a recommendation of the measures taken to provide support for health care professionals who are involved in safeguarding activity. This will include a recommendation for employing organisations to provide child protection supervision for all practitioners, by a practitioner who is in the role of designated nurse or nurse consultation for child protection. The document also must give minimum frequency of this supervision and the expectations of the outcome e.g. recorded discussion and documented plan of action including timescales for action and review. It is acknowledged that it is the responsibility of the health care professional to attend this supervision; however, the	Thank you for this helpful suggestion. Unfortunately, service provision and training are outside the scope of this document. We will pass your comment on to the implementation team at NICE who may have more input on this matter.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						employing organisation is also accountable for providing such structures to promote safe and effective practice.	
SH	Unite Health Sector	10	Full	4.1.2	37	The document would be enhanced with the inclusion of diagrams or photographs of the issue under discussion e.g. the descriptive of the bite would be easier to understand by all health care professionals with the inclusion of a diagram or photograph. This is true of the other descriptions in the document.	Thank you for your comment. This is an interesting suggestion but NICE's editorial policy does not allow us to use pictures in recommendations.
SH	Unite Health Sector	11	Full	4	General	This section is well referenced and informative. It will provide an excellent resource for practitioners in practice and will inform the ongoing learning of practitioners and the students that they are supporting to learn in and from practice.	Thank you.
SH	Unite Health Sector	12	Full	4	General	This section is extremely informative and provides the practitioner with a working document to use in practice. The content would be further enhanced with examples of cases when these conditions have been suspected i.e. the case study would outline the signs and symptoms and actions of those involved / those who suspected child maltreatment and an account of why maltreatment was suspected.	Thank you. It is not normal practice for NICE guidelines to highlight individual case studies.
SH	Unite Health Sector	13	Full	General	General	The document refers to the need to record everything that the healthcare professional sees and this is commended. However, Unite/CPHVA would also suggest the inclusion of statements to highlight the value of photographic evidence especially in cases where a child presents with trauma that is	Thank you for your comment. The GDG agrees that photographs can be helpful in the circumstances you mention but is also aware that such photographs need to be of good enough quality to perform their desired function. As the GDG does not expect the intended audience of the guidance to have this

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						difficult to describe. The photograph would be used to supplement the written account of the trauma / what is seen etc. However, it is acknowledged that the fine line between collecting information to undertake an assessment and collecting information to undertake an investigation must be explained in full and different roles must be allocated to the relevant healthcare professional. It is important that the document makes these distinctions in order to enhance its value to practitioners in practice.	skill, such a recommendation has not been made.
SH	Unite Health Sector	14	Full	5	General	Unite/ CPHVA supports the inclusion of reference to the child health promotion programme in this section.	Thank you. For information, this recommendation has been changed to: "Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include: immunisation, health and development reviews, screening."
SH	Unite Health Sector	15	full	6.1.35a	71	The statement must make it clear if the term 'unusual' refers to an unusual pattern for the client (child and / or carer) or if it refers to unusual pattern for anyone attending for healthcare services. If it refers to the latter then there must be some definitions / outlines of examples which are considered to be illustrating an unusual pattern of presentation. It is also important to acknowledge the under confident parent / carer (which many health visitors will come into contact with) who present frequently for health care services in order to gain reassurance that all is ok. The document should acknowledge when this may lead to an unusual presentation and suspicions	Thank you for raising this. The term 'unusual' will be subject to the health professional's clinical experience.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						of maltreatment. Furthermore the document must acknowledge the way in which people who are not familiar or confident with using and accessing primary care services and when this situation may present as an unusual presentation.	
SH	Unite Health Sector	16	Full	General	General	The document refers to the importance of record keeping and documentation which is appropriate and commendable. However, it is also imperative that the document includes reference to the importance of health care professionals completing a multi – agency / multi – professional record / assessment e.g. the common assessment framework (CAF) and the potential benefits that this would have on the outcome of actions when suspicions of child maltreatment exist.	Thank you for your comment. Common assessment frameworks are beyond the scope of this guidance.
SH	Unite Health Sector	17	Full	General	General	The document refers to the child health promotion programme however, does not include reference to other child and family related legislation e.g. The National Service Framework for children (DH 2001).	Thank you for your comment. The NSF is too general in this context.
SH	Unite Health Sector	18	Summary		2.1.16	Should read 'record exactly what they see and hear *and smell.*	Thank you for highlighting this. This has been amended to "record on the child or young person's clinical record exactly what is observed and heard from whom and when" to take account of your comment.
SH	Unite Health Sector	19	Summary		2.1.18	Needs to acknowledge that many children (who arrive here from other countries) have no previous health records. Also parent-child interaction is often not observable by school nurses, owing to the fact that parents aren't in school.	Thank you for this comment. The emphasis in the guidance is that one's consideration or suspicion is based on what one observes in the child. It is not about seeking indicators.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Unite Health Sector	20	Summary		2.1.35	Should read 'record exactly what they see and hear *and smell.*	Thank you for your comment. As stated above, the wording has been changed to: "record in the child's clinical record exactly what is observed and head from whom and when" to account for this.
SH	Unite Health Sector	21	Summary	5	24, line 27/28	*should also mention skin infections*	Thank you. The GDG believes that skin infections are covered in this recommendation.
SH	Unite Health Sector	22	Full	5	24 line 31/34	Should indicate that there may be reasons why the parent or carer cannot get to appointments, and that it is not necessarily the parents' fault, even though it does constitute neglect.	Thank you for your comment. This recommendation, as a' consider' recommendation, allows the health professional to explore explanations for presentations.
SH	Unite Health Sector	23	Full	5	24 line 39/40	Neglect is also where the parent/carer fails to provide toothbrush and toothpaste and supervision of oral health to prevent dental caries.	Thank you. We agree and believe that this is implicit in our recommendation.
SH	Unite Health Sector	24	Full	5	24 line 45/46	Needs to point out that the child may be a young carer, and that non attendance at school, while constituting neglect, may not be the parent's fault.	Thank you for your comment. For information, the reference to school non-attendance has been removed from this recommendation. The Children Act 1989 does not include intent to harm the child as part of the threshold for significant harm. While we agree that "fault" may not be parental the health care professional has responsibility to the child.
SH	Unite Health Sector	25	Full	6	26 line 1-15	Another line needs to be added 'the parent takes the child to a variety of health centres, walk in clin*ics, GPs and A&Es with differing complaints'*	Thank you for this suggestion. This is covered under "despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms".
SH	Unite Health	26	Full	7	27 line 15	*Needs to add 'picking at scars causing*	Thank you for this comment. The GDG's view

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Sector					*bleeding and infection'.*	is that the proposed addition is too detailed.
SH	Welsh Assembly Government	1	NICE	General	General	I have had a look at these guidelines and I think they do not contain anything new or surprising, but organize quite well material and advice which would be familiar to health professionals with an interest in this field. I think that they should be supported by information about training opportunities and local arrangements for advice and help. This would be particularly important to health professionals who, for whatever reason, are relatively inexperienced and have not had much contact with this problem. There are two problems for health professionals when dealing with child abuse: knowing when you've just seen it; and knowing what to do next. When abuse is serious and obvious the next step is fairly straightforward, but when it is more subtle it is difficult to know what the proportionate and appropriate response should be and this is where access to local advice which you can trust is so important. This is built in to the system through 'named' and 'designated' health professionals. We will need to be aware of the impact of the changes in the structure of the NHS on child protection arrangements. Perhaps we could send out a letter with the guidance and draw people's attention to what their local arrangements are and who to contact for help.	Thank you for commenting on this draft guidance. The GDG agrees that training is key and, although it is outside the scope of the guidance, it is something that will hopefully be addressed by the implementation team at NICE, to whom we will forward this comment. We support your suggestion of sending out a letter with the guidance to draw people's attention to what their local arrangements are and who to contact for help.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						Child protection arrangements can only be effective if professionals are trained and updated regularly and are comfortable that they know how their local arrangements work. This is an opportunity for us to help ensure that this continues to happen.	
SH	Welsh Assembly Government	2	NICE	1.1	14 Line 14	National Service Framework (NSF) for Children, Young People and Maternity Services. (Wales)	Thank you. This has been added.
SH	Welsh Assembly Government	3	NICE	1.1	14 Line 25	Safeguarding Children: Working Together under the Children Act 2004	Thank you for pointing this out. The definitions adopted by the GDG are those contained in the English document; since the definitions in the Welsh document are different we cite only the English document in this particular instance.
SH	Welsh Assembly Government	4	NICE	1.3	15 Line 16	Safeguarding Children: Working Together under the Children Act 2004	Thank you. The reference to the English document has been removed.
SH	Welsh Assembly Government	5	NICE	1.6	16 Line 26	Safeguarding Children: Working Together under the Children Act 2004 http://new.wales.gov.uk/topics/childrenyoungpeople/publications/guidance/1297522?lang=en	Thank you for your comment. This document has now been cited.
SH	Welsh Assembly Government	6	NICE	1.6	16 Line 28	Safeguarding Children in Whom Illness is Fabricated or Induced 2008 www.new.wales.gov.uk/topics/childrenyoungpeople/publications/guidance/illnessfabricated	Thank you for your comment. This document has now been cited.
SH	Welsh Assembly Government	7	NICE	2.1	20 Line 8,9,10	Re- order bullets	Thank you for your comment. The GDG does not believe that this is a practical suggestion.
SH	Welsh	8	NICE	2.1	20	Add the sentence: Cultural practices cannot	Thank you for your comment. This statement

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Assembly Government				Line 43	be used as an excuse for child maltreatment and may in fact be illegal DN – There are frequent references to cultural practices being mistaken for child maltreatment – it would be helpful if an example could be provided as we cannot think of any examples of cultural practices that may look like maltreatment and not be maltreatment.)	has been amended to ensure clarity. The GDG's view is that mentioning specific (and self-evidently) harmful practices has the potential to detract from the general message.
SH	Welsh Assembly Government	9	NICE	2.1	21 line 13	Safeguarding Children: Working Together Under the Children Act 2004	Thank you. This recommendation has been removed so there is no longer need to refer to the Welsh guidance here.
SH	Welsh Assembly Government	10	NICE	3.1	33 Line 10	delete	Thank you for your comment. This section has been amended because of lack of clarity in the previous version.
SH	Welsh Assembly Government	11	NICE	3.1	33 Line 39	suitable colleague delete	Thank you for this suggestion. The word 'suitable' has been replaced with 'experienced'.
SH	Welsh Assembly Government	12	NICE	3.1	34 Line 12	delete senior colleague and/or named	Thank you for your comment.This has been amended to: 'discuss the case with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague or a named or designated professional for safeguarding children'.
SH	Welsh Association of ME & CFS Support	1	Full	2.1.5	24	In lines 31,32 and 33 a child is considered to be neglected if they do not follow child health promotional programmes. In particular if exercise is contra-indicated due to a medical condition i.e. viral infection, Post Viral Fatigue, Myalgic Encephalomyelitis or Chronic Fatigue Syndrome and the child provides a medical certificate from an competent professional they should not be considered to be being neglected if they are excused from exercise,	Thank you for your comment. The reference to exercise has been removed from this recommendation.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						either in school or other appropriate facility.	
SH	Welsh Association of ME & CFS Support	2	Full	2.1.5	24	In lines 45.46 and 47 it should not be considered neglect if a child is not attending school on a regular basis due to illness which is covered by a medical certificate from a competent professional. In circumstances such as this the child should be offered education from home if the child is deemed by their health professional to be well enough.	Thank you for your comment. School attendance has been removed from this recommendation and is covered elsewhere in the document.
SH	Welsh Association of ME & CFS Support	3	Full	2.1.6	25	Lines 8,9,10 and 11 – A child should not be deemed to be being neglected if ill and attempting to access appropriate medical services. It is possible that children with PVFS, ME and CFS seek medical opinion from several health professionals to enable them to obtain an appropriate diagnosis and management of their condition and this should not be seen as 'doctor shopping' and therefore neglect.	Thank you for your comment. The section to which you refer is not about child neglect.
SH	Welsh Association of ME & CFS Support	4	Full	2.1.6	25	Lines 43 – 47 – A child should not be considered as suffering from FII if their medical presentation does not meet a 'recognised clinical picture'. Medicine is a devolving science and as such health professionals should keep an open mind as to new and evolving diseases.	Thank you for your comment. The GDG wishes to encourage open-mindedness in health professionals. However, this guidance is concerned only with diseases that have been discovered.
SH	Welsh Association of ME & CFS Support	5	Full	2.1.6	26	Line 5 – Some children will have 'poor reactions' to prescribed medications and treatments. This alone should not be seen as an indicator for FII.	Thank you for this comment which highlights the lack of clarity in the originally proposed 'suspect' recommendation. We have been working with the editorial team at NICE to ensure clarity and readability.
SH	Welsh	6	Full	2.1.6	26	Lines 9 and 10 – A child should not be	Thank you for your comment. It has been

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Association of ME & CFS Support					suspected of suffering from FII if it is necessary for them to seek out and consult several professionals in order to get the correct diagnosis and management advice for their condition. There is controversy amongst professionals about the management of conditions such as PVFS, ME and CFS and this should not be blamed on the child. If a child is 'Gillick' competent then they should have the right to choose their treatment.	noted. Please refer to NICE clinical guideline number 53 which contains information on the diagnosis and management of chronic fatigue syndrome.
SH	Welsh Association of ME & CFS Support	7	Full	2.1.6	26	Lines 11 and 12 - If there is controversy over the diagnosis and management advice given to a child over their condition FII is not an appropriate diagnosis if they are using aids and adaptations which have been prescribed by a competent professional or on the advice of a competent health professional they are not attending school.	Thank you. The GDG acknowledges that this is a possibility.
SH	Welsh Association of ME & CFS Support	8	Full	2.1.6	26	Lines 14 & 15 – FII is not an appropriate diagnosis when professionals and parents disagree about the diagnosis and management of their child's medical condition. In circumstances such as this mediation between the parents and professionals should be considered. It might be advisable to provide the parents with the clinical evidence to substantiate the advice given by the professional.	Thank you for your comment. The GDG agrees but you refer to service organisation, which is outside the scope of this guidance.
SH	Welsh Association of ME & CFS Support	9	Full	2.3	30	Lines 2, 3 & 4 – We do not consider the indicators for FII in the recommendations are valid for discriminating FII from other explanations. FII should not be considered when there is controversy over a medical condition such as ME and CFS. If there is	Thank you for your comment. The recommended validation study would set out to answer the question that you posed.

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
						disagreement between health professionals or health professionals and the child's parents/guardians as to the best management of children with ME & CFS the diagnosis of FII should not be considered without good grounds.	
SH	Welsh Association of ME & CFS Support	10	Full	6.1	71	Line 37 – Statement 35a, Round 2 – When a child has a condition which controversy surrounds such as ME & CFS numerous visits to doctors may be necessary 10 to obtain a diagnosis and 20 to obtain competent medical advice re management and school attendance. This does not mean that the child with ME or CFS has FII and the added pressure that comes with such a diagnosis can only be harmful for these children as it adds stress to an already uncertain time in their lives.	Thank you for your comment: 'considering' maltreatment in this instance means that explanations other than maltreatment are sought for this type of presentation.
SH	Welsh Association of ME & CFS Support	11	Full	6.7	79	Recommendations – It is recommended that FII is suspected if a child presents with a puzzling picture that does not fit a 'recognised clinical picture'. Many conditions do not fit such a picture and as such it is unreasonable to suggest that all these children are suspected of having FII. Controversy surrounds ME & CFS and as such it is not a condition which clearly slots into a clinically recognised picture. It is recognised that ME & CFS patients are a heterogeneous group and therefore patients present with different symptoms and therefore they will not easily fit into a 'recognised clinical picture'.	Thank you for your comment. Please refer to NICE clinical guideline number 53 which contains information on the diagnosis and management of chronic fatigue syndrome.
SH	Welsh Association of ME & CFS	12	Full	6.8	79	It is statutory duty to educate all children until the end of the school year in which they are 16. The responsibility is shared between the	Thank you for this comment. The text has been changed to: "All children of compulsory school age (the term following a child's fifth

Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Support					parents, the school and the Local Education Authority not as you state the 'Parents legal duty'. A suitable education constitutes one that is appropriate to the needs of the child and one which also takes into account their health needs. See relevant guidance fro m the Dept of Children and the Welsh Assembly Government.	birthday to the end of the school year in which they turn 16) must receive a suitable full time education. Parents are legally responsible for *ensuring this to be the case*, either at a school or by making other arrangements in conjunction with the local authority."
SH	Welsh Association of ME & CFS Support	13	Full	Appendix B	110	Unexplained fatigue should not be seen as a symptom that is seen as 'child maltreatment' and as such should be removed from this guideline. Unexplained fatigue can be a symptom in many many medical conditions and is not symptomatic of 'child maltreatment'.	Thank you for your comment. Please accept our apologies. Unexplained fatigue was included in this list erroneously. It has now been removed.
SH	Welsh Association of ME & CFS Support	14	Full	General	General	General comments about this guidance are positive but there are some instances where the guidance could be misconstrued as we have highlighted above. We think that the statutory bodies such as Social Services will struggle under the strain of the number of referrals of 'child maltreatment' that this guidance will engender. We do not believe that it will go any way to addressing the fears of doctors of being reported to their professional bodies etc	Thank you for raising this. An increase in referrals would be a welcome outcome and should, in the future, lead to an increase in the provision of services.

[i] http://www.nspcc.org.uk/Inform/publications/Downloads/itdoesnthappentodisabledchildren_wdf48044.pdf

[ii] CORE- info leaflets are produced by NSPCC in association with Cardiff University and as part of a rigorous systematic review led by Dr Alison Kemp. There purpose is to act as a quick but well informed guide for non-child protection clinicians and other health professionals.
http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html