When to suspect child maltreatment

NICE guideline

Draft for consultation, December 2008

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

Contents

Introduction

This guidance aims to provide a summary of clinical features associated with maltreatment that may be observed when a child presents to the NHS. When used in routine practice, the guidance should prompt healthcare professionals who are not specialists in child protection to think about the possibility of maltreatment. It is unusual in that its purpose 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.

This guidance does not enable NHS professionals to diagnose, confirm or disprove child maltreatment but is there to raise awareness; helping staff who are not specialists in child protection identify children who may be being maltreated, even if this is at a very early stage. Children may present with both physical and emotional features that may stem from one or more types of maltreatment.

There is compelling evidence, including that reported in the National Service Framework (NSF) for Children, Young People and Maternity Services, of the harmful short and long term effects of various forms of child maltreatment, affecting all aspects of the child's health, development and well-being which can last throughout adulthood. These effects can include anxiety, depression, substance misuse, self-destructive, oppositional or anti-social behaviours. In adulthood, there may be difficulties in forming or sustaining close relationships, sustaining work and potentially affecting future parenting capacity. Physical abuse can be fatal or result in lifelong disability or physical scarring and its psychological consequences. The NSF states that: 'The high cost of abuse and neglect both to individuals (and to society) underpins the duty on all agencies to be proactive in safeguarding children.'

In order for effective child protection to occur, all agencies must share information and cooperate, and do so at the earliest point possible. This guidance addresses the crucial contribution of healthcare professionals to this endeavour, by setting out the indicators which will alert healthcare professionals to the recognition of possible child maltreatment.

In this guidance, the following definitions of the forms of child maltreatment set out in 'Working together to safeguard children' (HM Government 2006)[1] are used:

Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may

[1] Working Together to Safeguard Children (2006). Available from www.everychildmatters.gov.uk/socialcare/safeguarding/workingtogether
Safeguarding Children in Whom Illness is Fabricated or Induced (2008). Available from www.everychildmatters.gov.uk/socialcare/safeguarding

include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Communicating with and about the child or young person

This guideline offers best practice advice on when to consider or suspect child maltreatment.[2]

Good communication between healthcare professionals and the child or young person as well as with their families and carers is essential. Communication should take into account additional needs such as physical, sensory or learning disabilities, or inability to speak or read English. Consideration should be given to cultural needs of children or young people and their families and carers.

When suspecting child maltreatment, healthcare professionals should work within local arrangements for safeguarding children, as set out in 'Working together to safeguard children' (DFES, 2006). If healthcare professionals have concerns about sharing information with others they should obtain advice from designated or named professionals. If concerns are based on information given by a child, healthcare professionals should explain to the child when they are unable to maintain confidentiality, explore the child's concerns about sharing this information and reassure the child that they will continue to be kept informed about what is happening.

[2] For definitions of ‘suspect’ and ‘consider’, see section 1.1.

1 Guidance

The following guidance is based on the best available evidence. The full guideline (www.nice.org.uk/CGXXXfullguideline) gives details of the methods and the evidence used to develop the guidance.

The definitions in section 1.1 are key to understanding and using the remainder of the guidance.

1.1 Guidance-specific definitions

1.1.1 For the purposes of this guidance, to suspect maltreatment means serious concern about the possibility of child maltreatment but is not proof of it; healthcare professionals should:

- record exactly what they see and hear
- record the nature of their concern
- follow local procedures on what to do when they think a child is being abused or neglected.

This may trigger a child protection investigation, supportive services may be offered to the family following an assessment, or alternative medical explanations may be identified.

1.1.2 For the purposes of this guidance, to consider maltreatment means that maltreatment is a possible explanation for a report/clinical feature or is included in the differential diagnosis. In considering the possibility of child maltreatment, the healthcare professional should:

- record exactly what they see and hear
- record the nature of their concern
- look for indicators of maltreatment in the history, parent–child interaction or the child's presentation now or in the past. This may lead the healthcare professional to suspect child maltreatment.

No further action is not an option if maltreatment is considered.

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.

1.2 Points for clinical practice and definitions

1.2.1 Healthcare professionals should seek an explanation for any injury that presents to them. Healthcare professionals should suspect child maltreatment when there is no explanation for a serious injury or the explanation proffered for any injury or presentation is implausible, inadequate or inconsistent with the child's presentation or medical condition. For example:

- discrepancies between the explanation and the child's age or developmental stage
- would not be expected to have occurred during this child's normal activities
- inconsistency in explanations between those given by the parent/carer and that given by child (unless the child is not at a developmental stage to give an account or it is considered inappropriate or not possible to obtain an account)
- inconsistency in explanations between those given by the child's parents or carers.

1.2.2 While not all disclosures may be accurate accounts of maltreatment, healthcare professionals should suspect

For definitions of **suspect** and **consider**, see section 1.1.

maltreatment if they receive a disclosure from a child. The professional should explain to the child the need to discuss this with another appropriate professional and the fact that they cannot keep this confidential.

1.2.3 Healthcare professionals should call appropriately on other disciplines and agencies in the process of substantiating or not substantiating child maltreatment.

1.2.4 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.

1.2.5 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.

1.2.6 Healthcare professionals should be aware that maltreatment in children with disabilities may be more difficult to recognise.

1.2.7 Healthcare professionals should be aware of deterrents to recognising possible child maltreatment, including fear of external challenges, risk of losing parents' confidence, resource implications and uncertainty about their suspicions.

1.2.8 Healthcare professionals should acknowledge that considering or suspecting maltreatment can be stressful and, when appropriate, should seek support from peers, senior colleagues and designated or named professionals.

1.2.9 Healthcare professionals should use the definitions of child maltreatment within 'Working Together to Safeguard Children' (2006) and its supplementary guidance. These include:

- exposure to domestic abuse
- prostitution
- exploitation or corruption of children and young people, including trafficking.

1.3 Physical features

Bruises

1.3.1 Healthcare professionals should suspect child maltreatment when a child has bruising in the shape of an implement, for example hand, ligature, stick or teeth, or a grip mark.

1.3.2 Healthcare professionals should suspect child maltreatment when there is bruising or petechiae (tiny red or purple spots) in the absence of a causative coagulation disorder or other relevant medical condition where the explanation for the bruising is implausible, inadequate, inconsistent or discrepant with the pattern of the bruising or the developmental stage of the child. Presentations include:

- bruising in babies and children who are not independently mobile
- multiple bruises or bruises in clusters
- bruises of uniform appearance
- bruises other than on bony prominences, for example bruises on face and neck.

Bites

1.3.3 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.

For definitions of **suspect** and **consider**, see section 1.1.

1.3.4 Healthcare professionals should consider neglect when there is a report or appearance of an animal bite in a child who has been inadequately supervised.

Cuts and abrasions

1.3.5 Healthcare professionals should suspect child maltreatment when a child has cuts, abrasions or scars that are in the shape of an implement or linear injuries around the neck, wrists or ankles suggesting ligatures or attempted strangulation.

1.3.6 Healthcare professionals should suspect child maltreatment when a child has cuts, abrasions or scars when the explanation is implausible, inadequate, inconsistent or discrepant with the pattern of injury or the developmental stage of the child. Presentations include:

- cuts and abrasions in babies and children who are not independently mobile
- multiple injuries of uniform appearance
- an injury to the genital area
- injuries with a symmetrical distribution
- injuries to areas usually protected by clothing (including back, chest, abdomen, axilla)
- injuries to the mouth, eyes, ears, neck and sides of face
- a pattern of previous or repeated injuries, for example multiple scars.

Thermal injuries

1.3.7 Healthcare professionals should suspect child maltreatment in a child with burn or scald injuries:

- when the explanation is absent, implausible, inadequate, inconsistent or discrepant with the pattern of thermal injury or the developmental stage of the child

For definitions of **suspect** and **consider**, see section 1.1.

- in babies, or children who are not independently mobile
- scalds that are indicative of forced immersion, for example:
  - scalds to buttocks, perineum and lower limbs
  - scalds to limbs in a glove and/or stocking distribution
  - scalds to limbs with symmetrical distribution
  - scalds with sharply delineated borders.
- contact burn/scald injuries on the backs of hands and soles of feet, buttocks, back and soft tissue areas that would not be expected to come into contact with a hot object in an accident, or
- contact burns in the shape of the implement used for example, cigarettes, irons.

Cold injury

1.3.8 Healthcare professionals should consider child maltreatment when a child has swollen, red hands and feet without obvious medical cause or when a child presents with hypothermia with no adequate explanation.

Hair loss

1.3.9 Healthcare professionals should consider child maltreatment when a child has hair loss due to inflicted hair-pulling.

Fractures

1.3.10 Healthcare professionals should consider child maltreatment when a child has a fracture in the absence of overt traumatic cause or known medical condition that predisposes to fragile bones (e.g. osteogenesis imperfecta, osteopenia of prematurity), particularly in children under 18 months.

For definitions of **suspect** and **consider**, see section 1.1.

1.3.11 Healthcare professionals should suspect child maltreatment when a child has a fracture and the explanation is absent, implausible, inadequate, inconsistent or discrepant with the pattern of fracture or the developmental stage of the child. Patterns include:

- multiple fractures
- multiple fractures of different ages
- x-ray evidence of occult fractures (fractures identified on x-rays that were not clinically evident), for example rib fractures in infants and toddlers.

Intra-cranial injuries

1.3.12 Healthcare professionals should suspect child maltreatment in any child with any clinical feature of intra-cranial injury in the absence of confirmed major accidental trauma or known medical cause:

- when there is an absent, implausible, inadequate or inconsistent explanation
- in an infant or toddler
- when there are intra-cranial injuries in association with:
  - retinal haemorrhages
  - rib and/or long bone fractures
  - other associated inflicted injuries
- when there are multiple extra axial bleeds including subdural haemorrhage and subarachnoid haemorrhage, with or without hypoxic ischaemic damage to the brain.

Eye trauma

1.3.13 Healthcare professionals should suspect child maltreatment when a child has retinal haemorrhages in the absence of major accidental trauma or a recognised medical cause including birth-related causes.

For definitions of **suspect** and **consider**, see section 1.1.

1.3.14 Healthcare professionals should suspect child maltreatment when a child has an injury to the eye and/or eyelids when the explanation is absent, implausible, inadequate, discrepant with the pattern of the injury or the developmental stage of the child or inconsistent.

Spinal injuries

1.3.15 Healthcare professionals should suspect physical abuse when a child presents with signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of witnessed significant trauma. This may also present as:

- a finding on skeletal survey or magnetic resonance imaging
- cervical injury in association with inflicted head injury
- thoracolumbar injury in association with focal neurology or unexplained kyphosis.

Visceral injuries

1.3.16 Healthcare professionals should suspect child maltreatment when a child has an intra-abdominal or intra-thoracic injury in the absence of an explanation of major accidental trauma or where the history is not consistent with the injury and in one or more of the following circumstances:

- delay in presentation
- absent, implausible, inadequate or inconsistent explanation
- may be in association with other injuries or in isolation, for example there is no external bruising or other injury.

Oral injury

1.3.17 Healthcare professionals should consider child maltreatment when a child has sustained an injury to the teeth, gums, tongue, frena or oral cavity where the explanation is absent, implausible, inadequate or inconsistent with the developmental level of the child.

For definitions of **suspect** and **consider**, see section 1.1.

Genital and anal symptoms/genital and anal signs

1.3.18 Healthcare professionals should consider sexual abuse when a girl or boy has discomfort on passing urine (dysuria) or ano-genital discomfort that is persistent or recurrent and is not explained by conditions such as worms, urinary infection, skin conditions, poor hygiene or known allergies.

1.3.19 Healthcare professionals should consider sexual abuse when a girl or boy has a genital or anal symptom such as genital or anal bleeding or genital or anal discharge without a medical explanation.

1.3.20 Healthcare professionals should suspect sexual abuse when a girl or boy has a genital or anal symptom such as genital or anal bleeding or genital or anal discharge without a medical explanation if these complaints are persistent or repeated, are associated with behavioural or emotional change and/or with other information that suggests the possibility of sexual abuse.

1.3.21 Healthcare professionals should suspect child sexual abuse when a girl or boy has a genital injury with an absent, implausible, inadequate or inconsistent explanation for the injury.

1.3.22 Healthcare professionals should suspect sexual abuse when a girl or boy has an anal fissure when constipation, Crohn's disease and passing hard stools have been excluded.

1.3.23 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.

1.3.24 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.

For definitions of **suspect** and **consider**, see section 1.1.

1.3.25 Healthcare professionals should consider child sexual abuse if there is evidence of foreign bodies in the vagina or anus, noting that foreign bodies may be indicated by offensive vaginal discharge in girls.

Sexually transmitted infections

1.3.26 Healthcare professionals should suspect sexual abuse in a child below the age of 13 years who 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 mother-to-child transmission during birth or blood contamination.

1.3.27 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.

1.3.28 Healthcare professionals should consider sexual abuse when a young person aged 16 or 17 years of age 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) when there is no clear evidence of blood contamination or that the STI was acquired from consensual sexual activity and one or more of the following is present:

- a clear discrepancy in power or mental capacity between the young person and their sexual partner, in particular where the relationship constitutes incest or is with those persons in

For definitions of **suspect** and **consider**, see section 1.1.

positions of trust, for example teacher, sports coach, minister of religion

- concern that the young person is being exploited or the sexual activity appears not to be consensual.

Pregnancy

1.3.29 Healthcare professionals must recognise that sexual intercourse in a child aged under 13 years is unlawful and therefore pregnancy constitutes maltreatment.

1.3.30 Healthcare professionals should consider sexual abuse when a young person aged 13 to 15 years is pregnant.

1.3.31 Healthcare professionals should consider sexual abuse when a young person aged 16 or 17 years of age is pregnant and one or more of the following is present:

- a clear discrepancy in power or mental capacity between the young woman and the putative father, in particular where the relationship constitutes incest or is with persons in positions of trust, for example teacher, sports coach, minister of religion, or
- concern that the young person is being exploited or that the sexual activity appears not to have been consensual.

1.4 Neglect – failure of provision and failure of supervision

General features of neglect

1.4.1 Healthcare professionals should consider neglect if a child's state of clothing or footwear is consistently inappropriate, for example, for the weather or the child's size.

1.4.2 Healthcare professionals should suspect neglect if a child is persistently smelly and dirty.

For definitions of **suspect** and **consider**, see section 1.1.

1.4.3 Healthcare professionals should suspect neglect if a child has persistent infestations, such as scabies or head lice, where no attempt has been made to treat them.

1.4.4 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.

1.4.5 Healthcare professionals 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.

1.4.6 Healthcare professionals should suspect neglect if parents or carers fail to promptly seek medical advice for their child to the extent that the child's health and well-being is compromised or the child is in ongoing pain.

1.4.7 Healthcare professionals should consider neglect if parents or carers fail to administer essential prescribed medication for their child.

1.4.8 Healthcare professionals should consider neglect if parents or carers persistently fail to obtain treatment for their child's dental caries.

1.4.9 Healthcare professionals should consider neglect if parents or carers persistently fail to attend follow-up outpatient appointments for their children that are essential to the child's health and well-being.

1.4.10 Healthcare professionals should consider neglect when the explanation for the injury, including a burn, suggests lack of appropriate supervision.

For definitions of **suspect** and **consider**, see section 1.1.

1.4.11 Healthcare professionals should consider neglect if a child is not being cared for by a person who is able to provide safe or adequate care, including ensuring regular school attendance at compulsory school age.

1.4.12 Healthcare professionals should be aware that abandonment constitutes neglect.

1.4.13 Healthcare professionals should suspect neglect if they encounter the following persistent home conditions: poor standard of hygiene such that a child's health may be affected, inadequate provision of food, living space that is inappropriate or unsafe for the child's developmental stage.

Over- and under-nutrition

1.4.14 Healthcare professionals should consider child maltreatment in any child with abnormal growth patterns for which there is no medical cause.

1.5 Clinical presentations

Repeated attendance at medical services

1.5.1 Healthcare professionals should consider child maltreatment when they become aware of:

- an unusual pattern of presentation to, and contact with, healthcare providers, or
- frequent presentations or reports of injuries.

Strangulation and suffocation

1.5.2 Healthcare professionals should suspect child maltreatment if a child shows signs of strangulation, for example bruising around the neck or ligature marks with or without facial petechiae, in the absence of a plausible, adequate or consistent explanation.

For definitions of **suspect** and **consider**, see section 1.1.

Apparent life-threatening event

1.5.3 Healthcare professionals should suspect child maltreatment with repeated presentations of an apparent life-threatening event where the onset is witnessed only by the carer and where underlying medical causes have not been identified.

1.5.4 Healthcare professionals should consider child maltreatment if an infant has an apparent life-threatening event with bleeding from the nose or mouth where underlying medical causes have not been identified.

Poisoning

1.5.5 Healthcare professionals should suspect child maltreatment, either neglect or inflicted harm, in cases of poisoning in children when:

- there is a report of inappropriate administration of substances, including prescribed and non-prescribed drugs
- there are unexpected blood levels of non-prescribed medication
- there is reported or biochemical evidence of ingestions of more than one toxic substance
- there is any case of poisoning in babies or children who would be unable to access the substance independently
- a child presents with poisoning and there is an absent, implausible, inadequate or inconsistent explanation for the poisoning or how the substance came to be in the child
- there have been repeated presentations of ingestions in the index child or other children in the household.

1.5.6 Healthcare professionals should consider child maltreatment in cases of hypernatraemic dehydration, which may arise from, for example, over-concentrated preparations of formula feeds as well as from deliberate salt poisoning.

For definitions of **suspect** and **consider**, see section 1.1.

Near drowning

1.5.7 Healthcare professionals should suspect child maltreatment when a near-drowning incident has an absent, implausible, inadequate or inconsistent explanation or when the child's presentation is inconsistent with the account. Child maltreatment should also be considered when the incident suggests a lack of supervision (see 'General features of neglect', section 1.4).

Fabricated or induced illness

1.5.8 Healthcare professionals should consider fabricated or induced illness if a child's history, physical or psychological presentations and/or findings of assessments, examinations or investigations yield a puzzling discrepancy to a recognised clinical picture. This still applies even if the child has a previous or concurrent established physical or psychological illness or disorder.

1.5.9 Healthcare professionals should suspect fabricated or induced illness if, in addition to the above, one or more of the following is present:

- reported symptoms and signs are not seen to begin if the carer is absent
- reported symptoms are only observed by the carer
- there is an inexplicably poor response to prescribed medication and other treatment
- new symptoms are reported on resolution of previous ones
- history of events which are biologically implausible (e.g. small infants with a history of very large blood losses who do not become unwell or anaemic)
- over time the child is repeatedly presented with a range of signs and symptoms; and multiple opinions are sought inappropriately and persistently in both primary and secondary care

For definitions of **suspect** and **consider**, see section 1.1.

- the child's normal, daily life activities are being compromised beyond that which might be expected for any medical disorder from which the child is known to suffer, for example school attendance, use of aids to daily living such as wheelchairs
- 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.

Inappropriate or unexplained poor school attendance

1.5.10 Healthcare professionals should consider child maltreatment if they become aware of poor school attendance that has no justification on health, including mental health, grounds.

1.6 Emotional, behavioural and interpersonal/social functioning

Emotional and behavioural states

1.6.1 Healthcare professionals should consider child maltreatment if a child or young person displays or is reported to display a marked change in behaviour or emotional state that constitutes a departure from the normal developmental trajectory for this child and is not explained by a known psychosocial stressor or medical cause. For example:

- recurrent nightmares containing similar themes
- extreme distress
- markedly oppositional behaviour
- withdrawn.

1.6.2 Healthcare professionals should consider child maltreatment if a child's behaviour or emotional state is not consistent with the child's age and developmental stage or the child's emotional state or behaviour cannot be explained by medical causes,

For definitions of **suspect** and **consider**, see section 1.1.

neurodevelopmental disorders (e.g. ADHD, autism spectrum disorders) or other psychosocial stressors (e.g. bereavement or parental separation). See lists below for examples.

Emotional state	Behaviour	Interpersonal behaviours
Fearful, Withdrawn Low self-esteem	Aggressive Oppositional	Indiscriminate contact/affection seeking or over-friendliness to strangers including healthcare professionals Excessive clinginess Persistently resorting to gaining attention Child fails to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed Socially isolated

1.6.3 Healthcare professionals should consider child maltreatment if a child shows repeated, extreme or sustained emotional responses out of proportion to a situation that are not expected for the child's developmental age or where a medical cause or neurodevelopmental disorder (for example ADHD, autism spectrum disorders and bipolar disorder) has been explored. These include:

- anger or frustration expressed as, for example, temper tantrum in a school-aged child or frequently flying into a rage at the least provocation
- distress expressed as, for example, inconsolable crying.

1.6.4 Healthcare professionals should consider child maltreatment if a child or young person regularly and persistently shows or is reported to assume age-inappropriate responsibilities which interfere with normal developmental tasks such as attending school. For example:

- a child may adopt a care-taking role for parents or siblings
- a very young child may show excessive comforting behaviours when witnessing parental distress
- children may demonstrate excessively 'good' behaviour to prevent parental disapproval.

For definitions of **suspect** and **consider**, see section 1.1.

1.6.5 Healthcare professionals should consider child maltreatment if a child responds to a health examination/assessment in an unusual, unexpected and developmentally inappropriate way, for example extreme passivity, resistance or refusal.

Self-harm

1.6.6 Healthcare professionals should consider past or current maltreatment, particularly sexual, physical or emotional abuse, as a reason for deliberate self-harm in a child or young person, including cutting, scratching, picking, biting or tearing skin to cause injury, taking prescribed or non-prescribed medications at higher than therapeutic doses when the intention is self-harm, pulling out hair or eyelashes.

Abdominal pain

1.6.7 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.

Disturbances in eating and feeding behaviour

1.6.8 Healthcare professionals should suspect child maltreatment in children who scavenge, steal, hoard or hide food in the absence of medical causes.

Selective mutism (elective mutism)

1.6.9 Healthcare professionals should consider child maltreatment when a child presents with selective mutism.

Body rocking

1.6.10 Healthcare professionals should consider emotional neglect if a child displays habitual body rocking in the absence of medical causes or neuro-developmental disorders.

For definitions of **suspect** and **consider**, see section 1.1.

Wetting and soiling

1.6.11 Healthcare professionals should consider child maltreatment in a child who has secondary day or night time wetting in the absence of medical causes (for example urinary tract infections), clearly identified psychosocial stressors (for example a death in the family, parental separation) which persists despite compliance with adequate management.

1.6.12 Healthcare professionals should consider child maltreatment in a child who is reported to be deliberately wetting.

1.6.13 Healthcare professionals should consider child maltreatment when there is a persistent punitive parental response to wetting against professional advice that the symptom is involuntary.

1.6.14 Healthcare professionals should consider child maltreatment in children showing encopresis (persistently defecating a normal stool in an inappropriate place) or persistent, deliberate smearing.

Sexualised behaviour

1.6.15 Healthcare professionals should suspect child maltreatment, particularly sexual abuse, when a pre-pubertal child displays or is reported to display repeated, coercive or persistent sexualised behaviours or preoccupation, such as sexual talk associated with knowledge, drawing genitalia, masturbation, emulating sexual activity.

1.6.16 Healthcare professionals should suspect a history of past or present maltreatment when a child or young person's sexual behaviour is indiscriminate, precocious or coercive.

1.6.17 Healthcare professionals should suspect sexual abuse when a pre-pubertal child displays or is reported to display unusual sexualised behaviours, including but not restricted to:

For definitions of **suspect** and **consider**, see section 1.1.

- oral-genital contact with another child or a doll
- requesting to be touched in the genital area
- inserting or attempting to insert an object, finger or penis into another child's vagina or anus.

Runaway behaviour

1.6.18 Healthcare professionals should consider child maltreatment if a child or young person has run away from home or care, or is living in alternative accommodation without the full agreement of the parent/s or carer/s.

Dissociation

1.6.19 Healthcare professionals should consider child maltreatment if a child shows dissociation (transient episodes of detachment from current interaction that are outside the child's voluntary control that can be distinguished from daydreaming, seizures or deliberate avoidance of interaction) that is not explained by a known traumatic event unrelated to maltreatment.

1.7 Parent–child interactions

1.7.1 Healthcare professionals should consider emotional abuse when there is concern that parent–child interactions may be harmful. These include:

- negativity, hostility towards, rejection of and/or scapegoating of a child
- developmentally inappropriate expectations of or interactions with a child including inappropriate threats or methods of disciplining
- exposure to frightening and/or traumatic experiences including domestic abuse
- using the child for the fulfilment of the parent's needs, for example, children being used in marital disputes

For definitions of **suspect** and **consider**, see section 1.1.

- 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.

If any of these interactions are persistent, this is emotional abuse.

1.7.2 Healthcare professionals should consider emotional neglect when there is emotional unavailability and unresponsiveness from the parent/carer towards the child. This includes the family which is high on criticism and low on warmth. If this is persistent, this is emotional abuse.

For definitions of **suspect** and **consider**, see section 1.1.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from www.nice.org.uk/guidance/index.jsp?action=download&o=35848.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Women's and Children's Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information in the booklet: 'The guideline development process: an overview for stakeholders, the public and the NHS' (third edition, published April 2007), which is available from www.nice.org.uk/guidelinesprocess or from NICE publications (phone 0845 003 7783 or email publications@nice.org.uk and quote reference N1233).

3 Implementation

The Healthcare Commission assesses how well NHS organisations meet core and developmental standards set by the Department of Health in 'Standards for better health' (available from www.dh.gov.uk). Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that NHS organisations should take into account national agreed guidance when planning and delivering care.

NICE has developed tools to help organisations implement this guidance (listed below). These are available on our website (www.nice.org.uk/CGXXX). *[NICE to amend list as needed at time of publication]*

- Slides highlighting key messages for local discussion.
- Costing tools:

  - costing report to estimate the national savings and costs associated with implementation
  - costing template to estimate the local costs and savings involved.
- Implementation advice on how to put the guidance into practice and national initiatives that support this locally.
- Audit support for monitoring local practice.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see section 5).

4.1 Fractures

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

Why this is important

A prospective comparative study of fractures in physical abuse, conditions leading to bone fragility and those resulting from accidental trauma to encompass a study of metaphyseal fractures specifically is needed because the existing evidence base does not fully account for differential diagnosis of fractures in the infant and toddler age group.

4.2 Ano-genital symptoms, signs and infections

What are the ano-genital signs, symptoms and presenting features (including emotional and behavioural features) that distinguish sexually abused from non-abused children?

Why this is important

A well-conducted prospective study is needed in this area to address problems of reporting bias in the existent literature, particularly in relation to non-abused children.

4.3 Fabricated or induced illness

Are the indicators of fabricated or induced illness (FII) as described in the recommendations valid for discriminating FII from other explanations?

Why this is important

Although the alerting signs have been developed based on clinical experience and are considered clinically useful in detecting FII, there is a need to establish their discriminant validity. This could be achieved by a prospective study.

4.4 Emotional and behavioural states

What aspects of behaviours and emotional states as alerting individual signs discriminate maltreated children from non-maltreated children in the healthcare setting?

Why this is important

Much of the research in this area uses composite scores from instruments or scenarios to discriminate maltreated from non-maltreated children. To translate these scores into items that are usable for healthcare professionals who are meeting children for the first time, it is necessary to know whether particular behavioural and emotional states can be used to identify maltreated children. A prospective comparative study in the healthcare setting is required.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'When to suspect child maltreatment' contains details of the methods and evidence used to develop the guideline. It is published by the

National Collaborating Centre for Women's and Children's Health, and is available from [NCC website details to be added], our website (www.nice.org.uk/CGXXXfullguideline) and the National Library for Health (www.nlh.nhs.uk). **[Note: these details will apply to the published full guideline.]**

5.2 Quick reference guide

A quick reference guide for healthcare professionals is available from www.nice.org.uk/CGXXXquickrefguide

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

5.3 'Understanding NICE guidance'

A summary for patients and carers ('Understanding NICE guidance') is available from www.nice.org.uk/CGXXXpublicinfo

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N1XXX). **[Note: these details will apply when the guideline is published.]**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about child maltreatment.

6 Related NICE guidance

Published

Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE clinical guideline 9 (2004). Available from www.nice.org.uk/CG9

Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE clinical guideline 16 (2004). Available from www.nice.org.uk/CG16

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

- Constipation in children: the diagnosis and management of idiopathic childhood constipation in primary and secondary care. NICE clinical guideline. (Publication expected March 2010.)
- Nocturnal enuresis in children (bedwetting): the management of bed-wetting in children. NICE clinical guideline. (Publication expected August 2010.)

7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

Appendix A: The Guideline Development Group

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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

[NICE to add]

[Name; style = Unnumbered bold heading]
[job title and location; style = NICE normal]

Appendix C: The algorithm