NICE National Institute for Health and Care Excellence

NICE guideline

Child maltreatment: when to suspect maltreatment in under 18s

Clinical guideline
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Introduction

This guidance provides a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals. Its purpose is to raise awareness and help healthcare professionals who are not specialists in child protection to identify children who may be being maltreated. It does not give healthcare professionals recommendations on how to diagnose, confirm or disprove child maltreatment.

Children may present with both physical and psychological symptoms and signs that constitute alerting features of one or more types of maltreatment, and maltreatment may be observed in parent– or carer–child interactions.

There is strong evidence of the harmful short- and long-term effects of child maltreatment. All aspects of the child's health, development and wellbeing can be affected. The effects of child maltreatment can last throughout adulthood and include anxiety, depression, substance misuse, and self-destructive, oppositional or antisocial behaviours. In adulthood, there may be difficulties in forming or sustaining close relationships, sustaining employment and parenting capacity. Physical abuse may result in lifelong disability or physical scarring and harmful psychological consequences, and may even be fatal. The National Service Framework (NSF) for Children, Young People and Maternity Services for England states '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.'

Definitions

Child maltreatment

Child maltreatment includes neglect, physical, sexual and emotional abuse, and fabricated or induced illness. This guidance uses the definitions of child maltreatment as set out in the document 'Working together to safeguard children'[1].

Age groups

This guidance uses the following terms to describe children of different ages:

- infant (aged under 1 year)
- child (aged under 13 years)

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- young person (aged 13–17 years).

Exclusions from the guideline

The following topics were outside the scope of this guideline and have therefore not been covered:

- risk factors for child maltreatment, which are well recognised. Examples include
  - parental or carer drug or alcohol misuse
  - parental or carer mental health problems
  - intra-familial violence or history of violent offending
  - previous child maltreatment in members of the family
  - known maltreatment of animals by the parent or carer
  - vulnerable and unsupported parents or carers
  - pre-existing disability in the child
- protection of the unborn child
- children who have died as a result of child maltreatment[2]
- diagnostic assessment and investigations (for example, X-rays)
- treatment and care of the child if maltreatment is suspected
- how healthcare professionals should proceed once they suspect maltreatment
- healthcare professionals' competency, training and behaviour
- service organisation
- child protection procedures
- communication of suspicions to parents or carers, or the child or young person
- education and information for parents or carers, or the child or young person.

Communicating with and about the child or young person

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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 the inability to speak or read English. Consideration should be given to cultural needs of children or young people and their families and carers.

If healthcare professionals have concerns about sharing information with others, they should obtain advice from named or designated professionals for safeguarding children. 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. When gathering collateral information from other health disciplines and other agencies, professionals need to use judgement about whether to explain to the family the need to gather this information for the overall assessment of the child.

Potential obstacles to recognising and responding to possible maltreatment

Healthcare professionals may come across many different obstacles in the process of identifying maltreatment but these should not prevent them from following the appropriate course of action to prevent further harm to the child or young person. Examples of potential obstacles include the following:

- Concern about missing a treatable disorder.
- Healthcare professionals are used to working with parents and carers in the care of children and fear losing a positive relationship with a family already under their care.
- Discomfort of disbelieving, thinking ill of, suspecting or wrongly blaming a parent or carer.
- Divided duties to adult and child patients and breaching confidentiality.
- An understanding of the reasons why the maltreatment might have occurred, and that there was no intention to harm the child.
- Losing control over the child protection process and doubts about its benefits.
- Stress.
- Personal safety.

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- Fear of complaints.

[1] Working together to safeguard children. Supplementary guidance to 'Working together' includes: Department of Health, Home Office (2000) Safeguarding children involved in prostitution; Department of Health, Home Office, Department for Education and Skills, Welsh Assembly Government (2002) Safeguarding children in whom illness is fabricated or induced; Home Office. Female Circumcision Act 1985, Female Genital Mutilation Act 2003, Home Office Circular 10/2004; Association of Directors of Social Services, Department of Education and Skills, Department of Heath, Home Office, Foreign and Commonwealth Office (2004) Young people and vulnerable adults facing forced marriage.

[2] It should be noted that there are special procedures that should be followed when a child dies unexpectedly.

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1 Guidance

The following guidance is based on the best available evidence. The full guidance gives details of the methods and the evidence used to develop the guidance.

Definitions of terms used in this guidance

The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

Consider

For the purposes of this guidance, to consider child maltreatment means that maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

Suspect

For the purposes of this guidance, to suspect child maltreatment means a serious level of concern about the possibility of child maltreatment but is not proof of it.

Unsuitable explanation

For the purposes of this guidance, an unsuitable explanation for an injury or presentation is one that is implausible, inadequate or inconsistent:

- with the child or young person's
    - presentation
    - normal activities
    - existing medical condition
    - age or developmental stage
    - account compared to that given by parent and carers
- between parents or carers
- between accounts over time.

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An explanation based on cultural practice is also unsuitable because this should not justify hurting a child or young person.

Using this guidance

If a healthcare professional encounters an alerting feature of possible child maltreatment that prompts them to consider, suspect or exclude child maltreatment as a possible explanation, it is good practice to follow the process outlined in 1–5 below (see also Appendix C):

1. Listen and observe

Identifying or excluding child maltreatment involves piecing together information from many sources so that the whole picture of the child or young person is taken into account. This information may come from different sources and agencies and includes:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party[3]
- child's appearance
- child's behaviour or demeanour
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person.

2. Seek an explanation

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner.

Disability

Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.
Healthcare professionals may need to seek appropriate expertise if they are concerned about a child or young person with a disability.

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3. Record

- Record in the child or young person's clinical record exactly what is observed and heard from whom and when.
- Record why this is of concern.

  At this point the healthcare professional may consider, suspect or exclude child maltreatment from the differential diagnosis.

4. Consider, suspect or exclude maltreatment

Consider

At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

When hearing about or observing an alerting feature in the guidance:

- look for other alerting features of maltreatment in the child or young person's history, presentation or parent– or carer–interaction with the child or young person now or in the past.

  Then do one or more of the following:

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines, having used professional judgement about whether to explain the need to gather this information for an overall assessment of the child.
- 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 features.

Suspect

If an alerting feature or considering child maltreatment prompts a healthcare professional to suspect child maltreatment they should refer the child or young person to children's social care, following Local Safeguarding Children Board procedures.

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

Exclude

Exclude maltreatment when a suitable explanation is found for alerting features. This may be the decision following discussion of the case with a more experienced colleague or after gathering collateral information as part of considering child maltreatment.

5. Record

Record all actions taken in 4 and the outcome.

1.1 Physical features

Bruises

1.1.1 Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

1.1.2 Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable[4]. Examples include:

- bruising in a child who is not independently mobile
- multiple bruises or bruises in clusters
- bruises of a similar shape and size
- bruises on any non-bony part of the body or face including the eyes, ears and buttocks
- bruises on the neck that look like attempted strangulation
- bruises on the ankles and wrists that look like ligature marks.

Bites

1.1.3 Suspect child maltreatment if there is a report or appearance of a human bite mark that is thought unlikely to have been caused by a young child.

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1.1.4 Consider neglect if there is a report or appearance of an animal bite on a child who has been inadequately supervised.

Lacerations (cuts), abrasions and scars

1.1.5 Suspect child maltreatment if a child has lacerations, abrasions or scars and the explanation is unsuitable[4]. Examples include lacerations, abrasions or scars:

- on a child who is not independently mobile
- that are multiple
- with a symmetrical distribution
- on areas usually protected by clothing (for example, back, chest, abdomen, axilla, genital area)
- on the eyes, ears and sides of face
- on the neck, ankles and wrists that look like ligature marks.

Thermal injuries

1.1.6 Suspect child maltreatment if a child has burn or scald injuries:

- if the explanation for the injury is absent or unsuitable[4] or
- if the child is not independently mobile or
- on any soft tissue area that would not be expected to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks, back) or
- in the shape of an implement (for example, cigarette, iron) or
- that indicate forced immersion, for example:
  - scalds to buttocks, perineum and lower limbs
  - scalds to limbs in a glove or stocking distribution
  - scalds to limbs with symmetrical distribution
  - scalds with sharply delineated borders.

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Cold injury

1.1.7 Consider child maltreatment if a child has cold injuries (for example, swollen, red hands or feet) with no obvious medical explanation.

1.1.8 Consider child maltreatment if a child presents with hypothermia and the explanation is unsuitable[4].

Fractures

1.1.9 Suspect child maltreatment if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity) or if the explanation is absent or unsuitable[4]. Presentations include:

- 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.

Intracranial injuries

1.1.10 Suspect child maltreatment if a child has an intracranial injury in the absence of major confirmed accidental trauma or known medical cause, in one or more of the following circumstances:

- the explanation is absent or unsuitable[4]
- the child is aged under 3 years
- there are also:
  - retinal haemorrhages **or**
  - rib or long bone fractures **or**
  - other associated inflicted injuries
- there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain.

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Eye trauma

1.1.11 Suspect child maltreatment if a child has retinal haemorrhages or injury to the eye in the absence of major confirmed accidental trauma or a known medical explanation, including birth-related causes.

Spinal injuries

1.1.12 Suspect physical abuse if a child presents with signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of major confirmed accidental trauma. Spinal injury may 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 (curvature or deformity of the spine).

Visceral injuries

1.1.13 Suspect child maltreatment if a child has an intra-abdominal or intrathoracic injury in the absence of major confirmed accidental trauma and there is an absent or unsuitable explanation[4], or a delay in presentation. There may be no external bruising or other injury.

Oral injury

1.1.14 Consider child maltreatment if a child has an oral injury and the explanation is absent or unsuitable[4].

General injuries

1.1.15 Consider child maltreatment if there is no suitable explanation for a serious or unusual injury.

Ano-genital signs and symptoms

1.1.16 Suspect sexual abuse if a girl or boy has a genital, anal or perianal injury (as evidenced by bruising, laceration, swelling or abrasion) and the explanation is absent or unsuitable[4].

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1.1.17 Suspect sexual abuse if a girl or boy has a persistent or recurrent genital or anal symptom (for example, bleeding or discharge) that is associated with behavioural or emotional change and that has no medical explanation.

1.1.18 Suspect sexual abuse if a girl or boy has an anal fissure, and constipation, Crohn's disease and passing hard stools have been excluded as the cause.

1.1.19 Consider sexual abuse if a gaping anus in a girl or boy is observed during an examination and there is no medical explanation (for example, a neurological disorder or severe constipation).

1.1.20 Consider sexual abuse if a girl or boy has a genital or anal symptom (for example, bleeding or discharge) without a medical explanation.

1.1.21 Consider sexual abuse if a girl or boy has dysuria (discomfort on passing urine) or ano-genital discomfort that is persistent or recurrent and does not have a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).

1.1.22 Consider sexual abuse if there is evidence of one or more foreign bodies in the vagina or anus. Foreign bodies in the vagina may be indicated by offensive vaginal discharge.

Sexually transmitted infections

1.1.23 Consider sexual abuse if a child younger than 13 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household or blood contamination.

1.1.24 Consider sexual abuse if a child younger than 13 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth or non-sexual transmission from a member of the household.

1.1.25 Suspect sexual abuse if a child younger than 13 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth or blood contamination.

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1.1.26 Consider sexual abuse if a young person aged 13 to 15 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity with a peer.

1.1.27 Consider sexual abuse if a young person aged 13 to 15 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, or that the infection was acquired from consensual sexual activity with a peer.

1.1.28 Consider sexual abuse if a young person aged 13 to 15 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth, blood contamination, or that the sexually transmitted infection (STI) was acquired from consensual sexual activity with a peer[5].

1.1.29 Consider sexual abuse if a young person aged 16 or 17 years has hepatitis B and there is:

- no clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity **and**
- a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- concern that the young person is being exploited.

1.1.30 Consider sexual abuse if a young person aged 16 or 17 years has anogenital warts and there is:

- no clear evidence of non-sexual transmission from a member of the household or that the infection was acquired from consensual sexual activity **and**
- a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- concern that the young person is being exploited.

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1.1.31 Consider sexual abuse if a young person aged 16 or 17 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection and there is:

- no clear evidence of blood contamination or that the STI was acquired from consensual sexual activity **and**
- a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- concern that the young person is being exploited.

1.2 Clinical presentations

Pregnancy

1.2.1 Be aware that sexual intercourse with a child younger than 13 years is unlawful and therefore pregnancy in such a child means the child has been maltreated[6].

1.2.2 Consider sexual abuse if a young woman aged 13 to 15 years is pregnant[7].

1.2.3 Consider sexual abuse if a young woman aged 16 or 17 years is pregnant and there is:

- a clear difference in power or mental capacity between the young woman and the putative father, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- concern that the young woman is being exploited **or**
- concern that the sexual activity was not consensual.

Apparent life-threatening event

1.2.4 Suspect child maltreatment if a child has repeated apparent life-threatening events, the onset is witnessed only by one parent or carer and a medical explanation has not been identified.

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1.2.5 Consider child maltreatment if an infant has an apparent life-threatening event with bleeding from the nose or mouth and a medical explanation has not been identified.

Poisoning

1.2.6 Suspect child maltreatment in cases of poisoning in children if:

- there is a report of deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs **or**
- there are unexpected blood levels of drugs not prescribed for the child **or**
- there is reported or biochemical evidence of ingestions of one or more toxic substances **or**
- the child was unable to access the substance independently **or**
- the explanation for the poisoning or how the substance came to be in the child is absent or unsuitable[4] **or**
- there have been repeated presentations of ingestions in the child or other children in the household.

1.2.7 Consider child maltreatment in cases of hypernatraemia (abnormally high levels of sodium in the blood) and a medical explanation has not been identified.

Non-fatal submersion injury

1.2.8 Suspect child maltreatment if a child has a non-fatal submersion incident (near-drowning) and the explanation is absent or unsuitable[4] or if the child's presentation is inconsistent with the account.

1.2.9 Consider child maltreatment if a non-fatal submersion incident suggests a lack of supervision.

Attendance at medical services

1.2.10 Consider child maltreatment if there is an unusual pattern of presentation to and contact with healthcare providers, or there are frequent presentations or reports of injuries.

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Fabricated or induced illness

1.2.11 Consider fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture. Fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition.

1.2.12 Suspect fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture and one or more of the following is present:

- Reported symptoms and signs only appear or reappear when the parent or carer is present.
- Reported symptoms are only observed by the parent or carer.
- An inexplicably poor response to prescribed medication or other treatment.
- New symptoms are reported as soon as previous ones have resolved.
- There is a history of events that is biologically unlikely (for example, infants with a history of very large blood losses who do not become unwell or anaemic).
- 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.
- The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.

Fabricated or induced illness is a likely explanation even if the child has a past or concurrent physical or psychological condition.

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Inappropriately explained poor school attendance

1.2.13 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 home education is not being provided.

1.3 Neglect – failure of provision and failure of supervision

Neglect is a situation involving risk to the child or young person. It is the persistent failure to meet the child or young person's basic physical or psychological needs that is likely to result in the serious impairment of their health or development. This may or may not be deliberate. There are differences in how parents and carers choose to raise their children, including the choices they make about their children's healthcare. However, failure to recognise and respond to the child or young person's needs may amount to neglect.

There is no diagnostic gold standard for neglect and therefore decision-making in situations of apparent neglect can be very difficult and thresholds hard to establish. It is essential to place the child or young person at the centre of the assessment.

Provision of basic needs

1.3.1 Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.

1.3.2 Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size).

Instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.

1.3.3 Suspect neglect if a child is persistently smelly and dirty.

Children often become dirty and smelly during the course of the day. However, the nature of the child's smell may be so overwhelming that the possibility of persistent lack of provision or care should be taken into account. Examples include:

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- child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit)
- if the dirtiness is ingrained.

1.3.4 Suspect neglect if you repeatedly observe or hear reports of the following home environment that is in the parents' or carers' control:

- a poor standard of hygiene that affects a child's health
- inadequate provision of food
- a living environment that is unsafe for the child's developmental stage.

  It may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents' or carers' ability to meet their children's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.

1.3.5 Be aware that abandoning a child is a form of maltreatment.

Malnutrition

1.3.6 Consider neglect if a child displays faltering growth (failure to thrive) because of lack of provision of an adequate or appropriate diet.

Supervision

Achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult. However, if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm it may constitute neglect.

1.3.7 Consider neglect if the explanation for an injury (for example, a burn, sunburn or an ingestion of a harmful substance) suggests a lack of appropriate supervision.

1.3.8 Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.

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Ensuring access to appropriate medical care or treatment

1.3.9 Consider neglect if parents or carers fail to administer essential prescribed treatment for their child.

1.3.10 Consider neglect if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and wellbeing.

1.3.11 Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include:

- immunisation
- health and development reviews
- screening.

1.3.12 Consider neglect if parents or carers have access to but persistently fail to obtain NHS treatment for their child's dental caries (tooth decay).

1.3.13 Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain.

1.4 Emotional, behavioural, interpersonal and social functioning

Emotional and behavioural states

1.4.1 Consider child maltreatment if a child or young person displays or is reported to display a marked change in behaviour or emotional state (see examples below) that is a departure from what would be expected for their age and developmental stage and is not explained by a known stressful situation that is not part of child maltreatment (for example, bereavement or parental separation) or medical cause. Examples include:

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

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- withdrawal of communication
- becoming withdrawn.

1.4.2 Consider child maltreatment if a child's behaviour or emotional state is not consistent with their age and developmental stage or cannot be explained by medical causes, neurodevelopmental disorders (for example, attention deficit hyperactivity disorder [ADHD], autism spectrum disorders) or other stressful situation that is not part of child maltreatment (for example, bereavement or parental separation). Examples of behaviour or emotional states that may fit this description include:

- Emotional states:
  - fearful, withdrawn, low self-esteem
- Behaviour:
  - aggressive, oppositional
  - habitual body rocking
- Interpersonal behaviours:
  - indiscriminate contact or affection seeking
  - over-friendliness to strangers including healthcare professionals
  - excessive clinginess
  - persistently resorting to gaining attention
  - demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
  - failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
  - coercive controlling behaviour towards parents or carers
  - very young children showing excessive comforting behaviours when witnessing parental or carer distress.

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1.4.3 Consider child maltreatment if a child shows repeated, extreme or sustained emotional responses that are out of proportion to a situation and are not expected for the child's age or developmental stage or explained by a medical cause, neurodevelopmental disorder (for example, ADHD, autism spectrum disorders) or bipolar disorder and the effects of any known past maltreatment have been explored. Examples of these emotional responses include:

- anger or frustration expressed as a temper tantrum in a school-aged child
- frequent rages at minor provocation
- distress expressed as inconsolable crying.

1.4.4 Consider child maltreatment if a child shows dissociation (transient episodes of detachment that are outside the child's control and that are distinguished from daydreaming, seizures or deliberate avoidance of interaction) that is not explained by a known traumatic event unrelated to maltreatment.

1.4.5 Consider child maltreatment if a child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).

1.4.6 Consider child maltreatment if a child responds to a health examination or assessment in an unusual, unexpected or developmentally inappropriate way (for example, extreme passivity, resistance or refusal).

Behavioural disorders or abnormalities either seen or heard about

Self-harm

1.4.7 Consider past or current child maltreatment, particularly sexual, physical or emotional abuse, if a child or young person is deliberately self-harming. Self-harm includes cutting, scratching, picking, biting or tearing skin to cause injury, pulling out hair or eyelashes and deliberately taking prescribed or non-prescribed drugs at higher than therapeutic doses.

Disturbances in eating and feeding behaviour

1.4.8 Suspect child maltreatment if a child repeatedly scavenges, steals, hoards or hides food with no medical explanation.

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Wetting and soiling

1.4.9 Consider child maltreatment if a child has secondary day- or night-time wetting that persists despite adequate assessment and management unless there is a medical explanation (for example, urinary tract infection) or clearly identified stressful situation that is not part of maltreatment (for example, bereavement, parental separation).

1.4.10 Consider child maltreatment if a child is reported to be deliberately wetting.

1.4.11 Consider child maltreatment if a child shows encopresis (repeatedly defecating a normal stool in an inappropriate place) or repeated, deliberate smearing of faeces.

Sexualised behaviour

1.4.12 Suspect child maltreatment, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, drawing genitalia, emulating sexual activity with another child).

1.4.13 Suspect past or current child maltreatment if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.

1.4.14 Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include:

- 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

1.4.15 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 their parents or carers.

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1.5 Parent–child interactions

1.5.1 Consider emotional abuse if there is concern that parent– or carer–child interactions may be harmful. Examples include:

- Negativity or hostility towards a child or young person.
- Rejection or scapegoating of a child or young person.
- Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining.
- Exposure to frightening or traumatic experiences, including domestic abuse.
- Using the child for the fulfilment of the adult's needs (for example, children being used in marital disputes).
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).

1.5.2 Suspect emotional abuse when persistent harmful parent– or carer–child interactions are observed or reported.

1.5.3 Consider child maltreatment if parents or carers are seen or reported to punish a child for wetting despite professional advice that the symptom is involuntary.

1.5.4 Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

1.5.5 Suspect emotional neglect if there is persistent emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

1.5.6 Consider child maltreatment if a parent or carer refuses to allow a child or young person to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.

[3] It is standard practice to refer to children's social services when a child or young person makes a disclosure of maltreatment (even though it may not be precise in every detail).

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[4] Unsuitable means implausible, inadequate or inconsistent. See section 1. For definitions of **suspect** and **consider**, see section 1.

[5] In these circumstances, consider should include discussion of your concerns with a named or designated professional for safeguarding children.

[6] Under the Sexual Offences Act 2003, any sexual intercourse with a child younger than 13 years is unlawful. However, the Crown Prosecution Service guidance indicates that if this sexual intercourse occurs between a person under 18 and a child under 13, and the sexual intercourse is genuinely consensual and the individuals concerned are fairly close in age and development, a prosecution is unlikely to be appropriate.

[7] Under the Sexual Offences Act 2003, any sexual intercourse with a child aged 13–15 years is unlawful. However, the Crown Prosecution Service guidance indicates that consensual sexual intercourse between a person under 18 and a child aged 13–15 years would not normally require criminal proceedings in the absence of aggravating features.

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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.

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 about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

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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'. 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.

- Slides highlighting key messages for local discussion.
- Costing statement.
- Audit support for monitoring local practice.

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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 be differentiated from those resulting from conditions that lead to bone fragility and those resulting from accidents, particularly in relation to metaphyseal fractures?

Why this is important

The existing evidence base does not fully account for the features that differentiate fractures from different causes in infants and pre-school age children. A prospective comparative study of fractures in physical abuse, those resulting from conditions that lead to bone fragility and those resulting from accidental trauma would help address this question. Any such study should encompass a study of metaphyseal fractures.

4.2 Anogenital warts

What is the association between anogenital warts and sexual abuse in children of different ages?

Why this is important

Anogenital warts can be acquired by vertical transmission, sexual contact and by non-sexual transmission within households. A thorough prospective study is needed to investigate the differential causes of anogenital warts in children. Such a study should include full viral typing of the warts in the index case and contacts where possible.

4.3 Fabricated or induced illness

Are the indicators of fabricated or induced illness as described in the recommendations (1.2.11, 1.2.12) valid for discriminating fabricated or induced illness from other explanations?

Why this is important

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

4.5 Recurrent abdominal pain

What is the association between unexplained recurrent abdominal pain and child maltreatment?

Why this is important

Recurrent abdominal pain is a common presentation in primary care and is often unexplained. A large observational study on the association between unexplained recurrent abdominal pain and child maltreatment is needed.

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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 our website.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

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

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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).
- 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).
- Constipation in children and young people. NICE clinical guideline 99 (2010).
- Nocturnal enuresis in children: the management of bed-wetting in children and young people. NICE clinical guideline 111 (2010).

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7 Changes after publication

February 2016: The guideline title has been changed to 'Child maltreatment: when to suspect maltreatment in under 18s'.

January 2014: Recommendation 1.2.1 footnote 6 has been further amended to ensure it accurately reflects Crown Prosecution Service guidance.

Recommendation 1.2.2 has been clarified by adding a footnote reflecting Crown Prosecution Service guidance.

March 2013: Recommendation 1.2.1 has been clarified by adding a footnote referencing the Sexual Offences Act 2003.

December 2009:

This guidance was reissued in December 2009 to correct a factual inaccuracy in recommendation 1.2.13.

The following recommendation was changed from:

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.

to:

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 home education is not being provided.

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8 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.

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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.

Dr Rob Walker (Chair)
General Practitioner, West Cumbria

Dr Mark Hill
Head of Medical Affairs, Novartis Pharmaceuticals UK Ltd

Ailsa Donnelly
Lay member

Dr John Harley
General Practitioner, North Tees PCT

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Appendix C: Using this guidance

The full guideline contains a flowchart on how to use this guidance.

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Women's and Children's Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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Accreditation

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