

## When to suspect child maltreatment overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

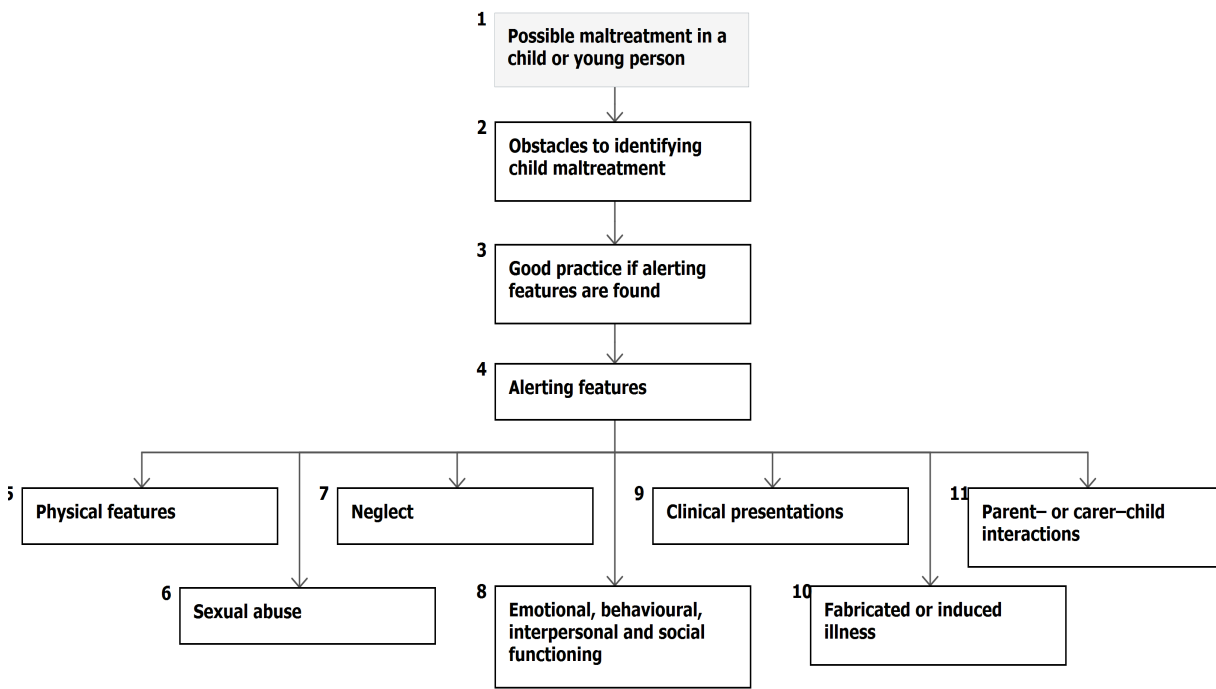
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<http://pathways.nice.org.uk/pathways/when-to-suspect-child-maltreatment>

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This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.

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## 1 Possible maltreatment in a child or young person

No additional information

## 2 Obstacles to identifying child maltreatment

Obstacles to identifying child maltreatment exist. However, these should not stop healthcare professionals from acting to prevent harm to the child. Examples of possible obstacles include:

- 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
- fear of complaints.

## 3 Good practice if alerting features are found

### Sharing information about children and young people

If you are worried about sharing information about a child or young person, seek advice from named or designated professionals for safeguarding children. If your concerns are based on information given by a child, explain to the child that you may be 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 who the information is being shared with and what action is being taken. When gathering collateral information from other health disciplines and agencies, use judgement about whether to explain to the child or young person the need to gather this information for their overall assessment.

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## Definitions of consider and suspect

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

**Consider** means maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

**Suspect** means serious level of concern about the possibility of child maltreatment but not proof of it.

## Good practice

If you encounter an alerting feature, it is good practice to follow the process outlined below:

### Listen and observe

Take into account the whole picture of the child or young person. Sources of information that help to do this include:

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

### 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. Be alert to an unsuitable explanation [See page 19].

### 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.

## **Consider, suspect or exclude maltreatment**

### **Consider child maltreatment**

If an alerting feature prompts you to consider child maltreatment:

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

And 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.
- 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.

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

### **Record**

Record all actions taken and the outcome.

### **Suspect child maltreatment**

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

### **Record**

Record all actions taken and the outcome.

### **Exclude child maltreatment**

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

## Record

Record all actions taken and the outcome.

### 4 Alerting features

Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.

### 5 Physical features

Alerting features that should prompt you to consider child maltreatment:

- Any serious or unusual injury with an absent or unsuitable explanation [See page 19].
- Cold injuries (for example, swollen, red hands or feet) in a child, with no medical explanation.
- Hypothermia in a child, with an unsuitable explanation.
- Oral injury in a child, with an absent or unsuitable explanation.

Alerting features that should prompt you to suspect child maltreatment:

- Bruising in the shape of a hand, ligature, stick, teeth mark, grip or an implement.
- Bruising or petechiae (tiny red or purple spots) not caused by a medical condition (for example, a coagulation disorder), with an unsuitable explanation, including those:
  - in a child who is not independently mobile
  - that are multiple or in clusters
  - of similar shape and size
  - on non-bony parts of the face or body, including the eyes, ears and buttocks
  - on the neck that look like attempted strangulation
  - on the ankles and wrists that look like ligature marks.
- Human bite mark thought unlikely to have been caused by a young child.
- Lacerations, abrasions or scars on a child that have an unsuitable explanation, including those:
  - in a child who is not independently mobile
  - that are multiple or have a symmetrical distribution
  - on areas usually protected by clothing, or the eyes, ears and sides of face

- on the neck, ankles and wrists that look like ligature marks.
- Burn or scald injuries on a child:
  - with an absent or unsuitable explanation **or**
  - who is not independently mobile **or**
  - on soft tissue areas not expected to accidentally come into contact with a hot object (for example, backs of hands, soles of feet, buttocks, back) **or**
  - in the shape of an implement (for example, cigarette or iron) **or**
  - that indicate forced immersion (for example, scalds to buttocks, perineum and lower limbs, to limbs in a glove, stocking or symmetrical distribution or with sharply delineated borders).
- One or more fractures in a child if there is no medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta or osteopenia of prematurity), or if the explanation is absent or unsuitable, including:
  - fractures of different ages
  - X-ray evidence of occult fractures (for example, rib fractures in infants).
- Intracranial injury in a child if there is no major confirmed accidental trauma or known medical cause in one or more of the following circumstances:
  - there is an absent or unsuitable explanation
  - the child is aged under 3 years
  - there are also other inflicted injuries, retinal haemorrhages, or rib or long bone fractures
  - there are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage to the brain.
- Retinal haemorrhages or injury to the eye in a child if there is no major confirmed accidental trauma or medical explanation, including birth-related causes.
- Signs of spinal injury (injury to vertebrae or within the spinal canal; for example, cervical injury with inflicted head injury, or thoracolumbar injury with focal neurology or unexplained kyphosis) in a child if there is no major confirmed accidental trauma.
- Intra-abdominal or intrathoracic injury in a child if there is no major confirmed accidental trauma, with an absent or unsuitable explanation, or with a delay in presentation. There may be no external bruising or other injury.

## 6 Sexual abuse

Sex with a child under 13 years is unlawful. Therefore pregnancy in a girl of this age means that she has been maltreated<sup>1</sup>.

Alerting features that should prompt you to consider sexual abuse:

<sup>1</sup> 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.



- Persistent or recurrent dysuria or anogenital discomfort, or an anal or genital symptom (for example, bleeding or discharge) in a girl or boy, without a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).
- Gaping anus in a girl or boy observed during an examination, without a medical explanation (for example, a neurological disorder or severe constipation). For more information, see [establishing whether constipation is present](#) in what NICE says on constipation.
- Evidence of a foreign body in the vagina or anus, indicated by, for example, offensive vaginal discharge.
- Hepatitis B in a child younger than 13 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household or blood contamination.
- Hepatitis B in a young person aged 13–15 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity with a peer.
- Hepatitis B in a young person aged 16 or 17 years and there is:
  - no clear evidence of vertical transmission, 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 with a person in a position of trust, for example, a teacher, sports coach or minister of religion) **or**
  - concern that the young person is being exploited.
- Anogenital warts in a child younger than 13 years if there is no clear evidence of vertical transmission or non-sexual transmission from a member of the household.
- Anogenital warts in a young person aged 13–15 years if there is no clear evidence of vertical transmission, non-sexual transmission from a member of the household or that the infection was acquired from consensual activity with a peer.
- Anogenital warts in a young person aged 16 or 17 years 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 with a person in a position of trust) **or**
  - concern that the young person is being exploited.
- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a young person aged 13–15 years if there is no clear evidence of vertical transmission, blood contamination or that the STI was acquired from consensual sexual activity with a peer<sup>1</sup>.
- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a young person aged 16 or 17 years and there is:

<sup>1</sup> In these circumstances, 'consider' should include discussion of your concerns with a named or designated professional for safeguarding children.

- 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 with a person in a position of trust) **or**
  - concern that the young person is being exploited.
- Pregnancy in a young woman aged 13–15 years<sup>1</sup>.
  - Pregnancy in a young woman aged 16 or 17 years 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 with a person in a position of trust) **or**
    - concern that the young woman is being exploited **or**
    - concern that the sexual activity was not consensual.

Alerting features that should prompt you to suspect sexual abuse:

- Persistent or recurrent genital or anal symptom (for example, bleeding or discharge) in a girl or boy, without a medical explanation, that is associated with behavioural or emotional change.
- Genital, anal or perianal injury in a girl or boy, with an absent or unsuitable explanation [See [page 19](#)].
- Anal fissure, when constipation, Crohn's disease and passing hard stools have been excluded as the cause. For more information, see establishing whether constipation is present in what NICE says on constipation.
- Gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection in a child younger than 13 years if there is no clear evidence of vertical transmission or blood contamination.
- Unusual sexualised behaviours in a prepubertal child (for example, oral–genital contact with another child or doll, requesting to be touched in the genital area, or inserting or attempting to insert an object, finger or penis into another child's vagina or anus).

## 7 Neglect

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 constitute neglect.

<sup>1</sup> 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.

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

If a child has been abandoned this is child maltreatment.

Alerting features that should prompt you to consider neglect:

- Severe and persistent infestations (for example, scabies or head lice) in a child.
- Parents or carers who do not administer essential prescribed treatment for their child.
- Parents or carers who have access to but persistently fail to obtain NHS treatment for their child's tooth decay.
- Parents or carers who repeatedly fail to attend essential follow-up appointments that are necessary for the health and wellbeing of their child.
- Parents or carers who persistently fail to engage with relevant child health promotion programmes which include immunisation, health and development reviews, and screening.
- Child who is consistently dressed in clothes or shoes that are 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 or slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.
- Faltering growth (failure to thrive) in a child because an adequate or appropriate diet is not being provided.
- Child or young person is not being cared for by a person who is able to provide adequate care.
- Animal bite on an inadequately supervised child.
- Injury (for example, a burn, sunburn or an ingestion of a harmful substance) if the explanation suggests lack of appropriate 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.

Alerting features that should prompt you to suspect neglect:

- Medical advice is not sought, compromising the health and wellbeing of a child, including if they are in ongoing pain.
- Child who is persistently smelly and dirty.

Children often become smelly or dirty 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:

- child seen at times of the day when it is unlikely that they would have had an opportunity to become smelly or dirty (for example, an early morning visit)
- if the dirtiness is ingrained.
- Repeated observation or reports of any of the following home environments that are in the parents' or carers' control:
  - poor standard of hygiene that affects the child's health
  - inadequate provision of food
  - 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 child's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.

## 8 Emotional, behavioural, interpersonal and social functioning

Alerting features that should prompt you to consider child maltreatment:

- Any behaviour or emotional state in a child if it is inconsistent with their age and developmental stage or there is no medical explanation (including a neurodevelopmental disorder, for example, ADHD or autism spectrum disorders) or other stressful situation unrelated to maltreatment (for example, bereavement or parental separation). Behaviour or emotional states that may fit this description include:
  - fearful or withdrawn emotional state
  - low self-esteem
  - aggressive or oppositional behaviour
  - habitual body rocking
  - indiscriminate contact or affection-seeking
  - over-friendliness to strangers
  - 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.
- Child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).
  - Marked change in behaviour or emotional state not expected for the child or young person's age and developmental stage (for example, recurrent nightmares with similar themes, extreme distress, becoming withdrawn, markedly oppositional behaviour or withdrawal of communication) in the absence of a medical explanation or known stressful situation unrelated to maltreatment.
  - Repeated, extreme or sustained emotional responses shown by a child that are out of proportion to a situation and are not expected for the child's age and developmental stage (for example, frequent rages at minor provocation, anger or frustration expressed as a temper tantrum in a school-aged child or distress expressed as inconsolable crying) in the absence of a medical explanation, neurodevelopmental disorder (for example, ADHD or autism spectrum disorders) or bipolar disorder when the effects of any known past maltreatment have been explored.
  - Dissociation displayed by a child, not explained by a known traumatic event that is unrelated to maltreatment.
  - Deliberate self-harm. 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. (See also what NICE says on [self-harm](#).)
  - Child or young person who has run away from home or care, or is living in alternative accommodation without the full agreement of parents or carers.
  - Unusual, unexpected or developmentally inappropriate response by a child to a health examination or assessment (for example, extreme passivity, resistance or refusal).
  - Secondary day- or night-time wetting in a child, which persists despite adequate assessment and management, if there is no known stressful situation unrelated to maltreatment or medical explanation (for example, urinary tract infection). For more information about possible causes of bedwetting, see what NICE says on [consider systemic causes, triggers, comorbidities and other factors](#) in assessment and investigation of bedwetting in children and young people.
  - Deliberate wetting by a child.
  - Encopresis or repeated, deliberate smearing of faeces by a child.

Alerting features that should prompt you to suspect child maltreatment:

- Child who repeatedly scavenges, steals, hoards or hides food with no medical explanation.
- Indiscriminate, precocious or coercive sexual behaviour in a child or young person.

- Repeated or coercive sexualised behaviours or preoccupation in a prepubertal child (for example, sexual talk associated with knowledge, drawing genitalia or emulating sexual activity with another child).

See what NICE says on [harmful sexual behaviour among children and young people](#).

## 9 Clinical presentations

Alerting features that should prompt you to consider child maltreatment:

- Unusual pattern of presentation to and contact with healthcare professionals, or frequent presentations or reports of injuries.
- Poor school attendance that the child's parents or carers know about that is not justified on health (including mental health) grounds, and home education is not being provided.
- Bleeding from the nose or mouth in an infant who has an apparent life-threatening event and a medical explanation has not been identified.
- Hyponatraemia if a medical explanation has not been identified.
- A near-drowning incident that suggests a lack of supervision.

Alerting features that should prompt you to suspect child maltreatment:

- Repeated apparent life-threatening events in a child, if the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
- Poisoning in a child in any of the following circumstances:
  - deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs
  - unexpected blood levels of drugs not prescribed for the child
  - reported or biochemical evidence of ingestions of one or more toxic substances
  - the child could not access the substance independently
  - repeated presentations of ingestions of substances in the child or other children in the household
  - there is an absent or [unsuitable explanation](#) [See page 19].
- Child has a near-drowning incident with an absent or unsuitable explanation.

## 10 Fabricated or induced illness

Alerting features that should prompt you to consider fabricated or induced illness:



- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture, even if the child has a past or concurrent physical or psychological condition.

Alerting features that should prompt you to suspect fabricated or induced illness:

- Child's history, physical or psychological presentation, or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture plus one or more of the following, even if the child has a past or concurrent physical or psychological condition:
  - reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer
  - an inexplicably poor response to prescribed medication or other treatment
  - new symptoms are reported as soon as previous symptoms stop
  - biologically unlikely history of events
  - 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
  - child's normal daily activities (for example, school attendance) are limited, or they are using aids to daily living (for example, wheelchairs) more than expected from any medical condition that the child has.

## 11 Parent– or carer–child interactions

Alerting features that should prompt you to consider child maltreatment:

- Potentially harmful parent– or carer–child interactions (emotional abuse), including:
  - 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 to fulfil the adult's needs (for example, in marital disputes)
  - failure to promote the child's appropriate socialisation (for example, not providing stimulation or education, isolation or involving them in unlawful activities).
- Emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).

- Parent or carer prevents you or another healthcare professional from speaking to the child or young person alone when it is necessary for the assessment of the child or young person.
- Parents or carers punishing a child for wetting despite professional advice that the wetting is involuntary. For more information about possible causes of bedwetting, see what NICE says on [consider systemic causes, triggers, comorbidities and other factors](#) in assessment and investigation of bedwetting in children and young people.

Alerting features that should prompt you to suspect child maltreatment:

- Persistent harmful parent– or carer–child interactions (emotional abuse).
- Persistent emotional unavailability and unresponsiveness from the parent or carer towards a child (in particular towards an infant) (emotional neglect).

For children or young people who also have, or may have, attachment difficulties, see what NICE says on [attachment difficulties in children and young people](#).

## Unsuitable explanation

An unsuitable explanation is one that is:

- implausible, inadequate or inconsistent:
  - with the child or young person's presentation, normal activities, medical condition (if one exists), age or developmental stage, or account compared with that given by parent and carers
  - between parents or carers
  - between accounts over time
- based on cultural practice, because this should not justify hurting a child or young person.

## Glossary

### Child

under 13 years

### Child maltreatment

includes physical, emotional and sexual abuse, neglect, and fabricated or induced illness (the definitions of child maltreatment in [Working together to safeguard children \(2010\)](#) are used in this guidance)

### Consider

maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis

### Dissociation

transient episodes of detachment that are outside the child's control and that are different from daydreaming, seizures or deliberate avoidance of interaction

### Encopresis

repeatedly defecating a normal stool in an inappropriate place

**Infant**

under 1 year

**Suspect**

serious level of concern about the possibility of child maltreatment but not proof of it

**Young person**

13–17 years

**Sources**

[Child maltreatment: when to suspect maltreatment in under 18s \(2009\) NICE guideline CG89](#)

**Your responsibility**

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. 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 which would be inconsistent with compliance with those duties.

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