

Kinderschutz LEITLINIE



AWMF S3(+) Child abuse and neglect guideline: involving Youth Welfare and Education Services (Child Protection Guideline)

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*To reflect the amendments made to the Law on Cooperation and Information in
Child Protection (KKG)*

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ENGLISH TRANSLATION

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Preamble

This guideline on the abuse and neglect of children are the result of a four-year process of participating representatives from the fields of youth welfare services, medicine, education, psychology, psychotherapy and social work.

The decision to develop scientific and overarching guidelines was made in 2011 as part of the Round Table on Sexual Abuse. The coordination was carried out by the medical field with support from 82 specialised associations, organisations, Federal Ministries and Federal Commissioners.

Together, the decision was made that the detection, identification, safeguarding and protection against re-victimisation in the event of abuse and/or neglect of children, would serve as the basis for the scientific work. This led to the development of diagnostic courses of action in the event of abuse and neglect, with the objective of giving specialised staff certainty when dealing with suspected cases and to protect children and adolescents.

During the development of these guidelines, everyone involved constructively grappled with the question of what the significance of the detection, identification, safeguarding and protection against re-victimisation has with regard to child protection. It became clear that the development of comprehensive "Children's Protection Guideline" is not yet complete and that these guidelines cannot claim to be complete.

One objective of the Guideline is to objectify such indicators for maltreatment (abuse or neglect), create a prognosis with regard to endangerment of the child, and to convey this assessment with certainty. This is directed to the children, adolescents and primary caregivers as well as to the specialised staff involved in child protection procedures.

In order to achieve this goal, the continuation of the constructive cooperation between all partners in child protection with the involvement of the children and adolescents themselves is desirable.

This guideline is based on German laws and reflects the processes in the healthcare and child and youth welfare services in Germany.

The Child Protection Guideline Office

1 Information

1.1 General information

The welfare and protection of children could begin with the ascertainment of pregnancy and ends with the completion of the 18th year of life. This results in a large number of service area intersections for children and adolescents as well as their families. In the Child Protection Guideline, the 'main care provision areas' are described based on youth welfare services, medicine/psychology, and education. The intersections are described and the tasks of the care provision areas and how they interact are taken into account, in order to formulate recommended actions for medical child protection.

Under the auspices of the German Medical Society for Child Protection (Deutsche Gesellschaft für Kinderschutz in der Medizin - DGKiM), the S3(+) Child abuse and neglect guideline: involving Youth Welfare and Education Services (Child Protection Guideline), have been developed in collaboration with 82 expert associations from the fields of healthcare, youth welfare services and education. The partners for child welfare and child protection representatively present this composition with the intention of contributing to the improvement of the structured course of action and the collaboration.

The S3 (+) Child Protection Guideline are divided into 22 subject areas:

MEDICAL IMAGING

DIFFERENTIAL DIAGNOSIS

EMOTIONAL NEGLECT/ABUSE

DEVELOPMENTAL AND BEHAVIOURAL DIFFICULTIES

FORENSIC INTERVIEW

FRACTURES

EARLY RECOGNITION OF FAMILIES' NEED FOR SUPPORT AND ASSISTANCE

CHILD SIBLINGS

HAEMATOMAS and THERMAL INJURIES

INFORMATION EXCHANGE - PSYCHOLOGICAL WELLBEING AND MENTAL HEALTH OF PREGNANT WOMEN AND PARENTS*

PEDIATRIC CHECK-UPS (KINDER-FRÜHERKENNUNGSUNTERSUCHUNG)

COOPERATION

MANDATORY REPORTING AND INFORMATION EXCHANGE

NEONATAL ABSTINENCE SYNDROME

OPS 1-945 (DIAGNOSIS IN CASE OF SUSPECTED THREAT TO CHILD WELFARE AND HEALTH)

PARTICIPATION

SCREENING PROCEDURE

SEXUAL ABUSE

CHILDREN AND ADOLESCENTS OF PARENTS* WITH ADDICTION PROBLEMS

PARENT* INTERVENTION

EYE EXAMINATION

DENTAL EXAMINATION

*Parents, primary caregiver and attachment figure

These subject areas of the present Child Protection Guideline cover a majority of subjects with regard to abuse and neglect of children, whereby the problems in question were not solely developed on the basis of direct clinical relevance. This was a conscious choice made from the start, in order to allow for

necessary relevance of the multi-professional approach, to consider the needs of various care provision areas, and finally, to focus on children and adolescents. The objective of developing the Guidelines in a child-centred, practical and process-oriented manner was paramount. And so, real cases from the various care provision fields were the basis for the development of case vignettes and the problems in question for evidence-based literature research (see Chapter 3.3).

In addition to the long version and work materials, a guideline version for children and youth was released on 11/02/2019. The short version and the version for social workers and educators are currently being revised with the help of everyone involved, and will be released by 31/08/2019. The systematic formulation of the Guideline and the underlying methodology are portrayed in the Guidelines Report and evidence treatment.

1.1.1 Publisher

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1.1.2 Citation format in the English translation

Child Protection Guideline Office. AWMF S3+ Child abuse and neglect guideline: involving Youth Welfare and Education Services (Child Protection Guideline), English translation 1.0, 2019, AWMF register number: 027 – 069

1.2 Responsibilities

1.2.1 Authors of the Guideline

The authors are presented in alphabetical order: Blesken, M., Franke, I., Freiberg, J., Kraft, M., Kurylowicz, L., Rohde, M., Schwier, F.

1.2.2 Methodical support

In order to clarify methodical questions efficiently due to the size of the guidelines group, a steering committee was founded at the constituent assembly. Those mandated who were involved in the steering committee are marked with ¹ in Chapter 1.2.3, and the relevant associations are listed in Chapter 1.2.4.

The guidelines portal for CGS (Clinical Guideline Services) supported the communication and the methodical literature work.

Prof. Dr. Ina Kopp (AWMF), Marburg, acted as a consultant for the staff in the Guidelines office at the start of the guideline development process.

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² advisory function: Expert association or organisation does not have voting power at the consensus meeting

Those formerly mandated are shown in brackets ().

³ only mandated for participation at the consensus conference

* no IKE available by 29/01/2019: Note: Influence on the Guidelines is minimal as no commenting takes place via the online CGS guideline portal, also it was not an option and no participation in the consensus conference followed.

2 Fundamentals for specialised staff

2.1 Common duties

Promoting and ensuring the welfare and health of children is the duty of all specialised staff that are responsible for children and adolescents. This also includes assessing a threat to children and adolescents, and helping avert a threat to children and adolescents.

2.2 Language as a challenge

2.2.1 Threat to child welfare

The term 'threat to child welfare' is based on the formulation of the BGH's (Federal Court of Justice) ruling from 1956.

A **threat to child welfare as laid down in § 1666 I BGB (German Civil Code)** is present when a current existing threat is ascertained to such a degree that if things continue to progress, considerable damage to the mental or physical well-being of the child can be expected with a sufficient degree of probability. The more serious the threat of damage, the fewer the requirements for the probability of occurrence of damage.

BGH FamRZ 1956, 351; BGH 23.11.2016 – XII ZB 149/16

Different usage of the term 'threat to child welfare' led to controversies during the development of the Guidelines again and again.

This controversy illustrated that the diagnostic procedure for abuse and/or neglect of children alone is not sufficient to assess a threat to child welfare. Rather, in addition to the diagnostic procedure, the assessment of current damages and the evaluation of consequential damage is required, in order to make a prognostic statement about the development of the children and adolescents and to convey this assessment. In order to clarify the future perspective of the children and adolescents, the benefit of assistance and support measures from all care provision areas should be checked and discussed with those involved, especially with the children and adolescents, and the primary caregivers. Among other things, the assessment of the parents' willingness and ability to avert potential harm to their child plays a key role.



Abuse and/or neglect of children are defined by "The single or combined occurrence of: physical abuse, emotional abuse, physical neglect, emotional neglect, or sexual abuse of children between 0 and 18 years of age". These are [serious indicators](#) of a threat to child welfare.

The term 'threat to child welfare' was initially defined independently by the Child Protection Guidelines. A separate definition that differed from the the legal definition used by youth welfare services, resulted from the necessity to label indicators of a threat to child welfare, such as abuse and/or neglect. A threat to child welfare is defined by a diagnosis based on the forms of abuse and/or neglect of children whereby the necessary prognostic evaluation on the development of children and adolescents has not been explicitly named. The Child Protection Guideline do not use this separate definition of the threat to child welfare and use the term 'threat to child welfare' based on the BGH-ruling, in order to counter

the risk of the different language usage leading to basic misunderstandings amongst the care provision areas.

The basic requirement for a common understanding of child protection is standardised language usage. In the future, a challenge will be the development of common terminologies and courses of action in order to improve child protection.

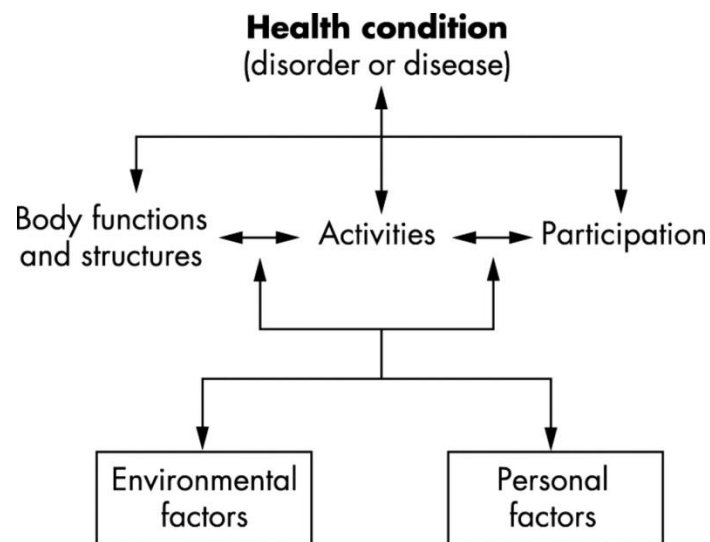
2.2.2 Contextual factors

The International Classification of Functioning, Disability and Health (ICF) is a classification from the World Health Organisation (WHO). According to the International Classification of Functioning (ICF) contextual factors outline a person's entire personal background. They comprise two components: Environmental factors and personal factors. These can either have a positive or negative influence on a person's functional capability, disability, and health.

Personal factors refer to the person's health, disability or functional capability, and include age, gender, and living conditions.

The environmental factors influence all components of the person's functional capability, health, and disability. These correlate with the person's physical and social involvement with their environment. These factors include already existing connections as well as access opportunities to social, health, or assistance systems, and among other things affect education, work, and housing conditions, as well as relationships to other people, attachment figures or caregivers (see Fig. 1).

Fig.1 WHO International Classification of Functioning, Disability and Health – correlations

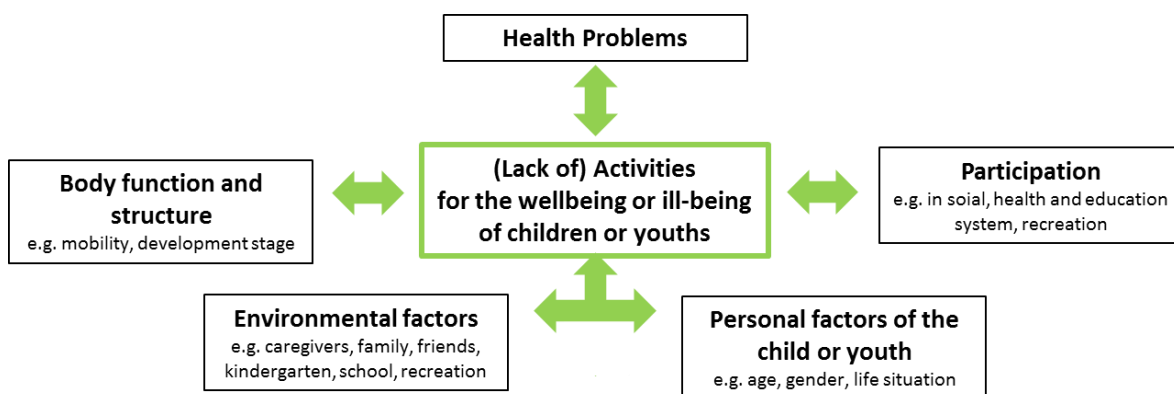


Contextual factors, with regard to child welfare and child health (see Fig. 2)

Contextual factors and/or personal and environmental factors correlate with the welfare and health of a child. They influence the physical, emotional and psychological development as well as the well-being of children and adolescents in a positive or negative manner.

The positive and negative influences of these contextual factors with regard to the welfare of children and adolescents are documented and can help assess a threat to children and adolescents. The welfare and development of children and adolescents whose primary caregiver plays a key role in their environment are strongly influenced by their stressors and resources. The stressors and resources of the primary caregivers are an important factor for assessing a threat to children and adolescents.

Fig. 2 Correlations of contextual factors, related to child welfare and child health



2.2.3 Serious indicators of a threat to child welfare

Specialised staff are alerted to serious indicators of a threat to child welfare through the awareness of indications and information about acts against children and adolescents, who experience physical, emotional or sexual abuse or are threatened by such, as well as the awareness that children and adolescents are being emotionally or physically neglected and are denied assistance and support measures.

A serious indicator of a threat to child welfare is present if children and adolescents themselves report or disclose a form of abuse. If a disclosure of this kind has not been made by the children or adolescents, serious indicators can also exist based on the statements of third parties or based on situations and findings that have been observed or examined by specialised staff, and then documented, analysed and assessed. Thus, children and adolescents can show indications of injuries or other abnormalities that give rise to a suspected threat to child welfare.

In each case of a suspected threat to child welfare, specialised staff must take the age and level of development of the children and adolescents as well as the contextual factors into account. The awareness to identify definite indicators of a threat to child welfare are just as essential as the following: the awareness of legally regulated entitlement to seek advice from a specialised professional with experience in this regard in cases of a suspected threat to child welfare, as well as the counselling of primary caregivers, children and adolescents in the case of serious indicators of a threat, and the legal authority to forward protected information to the Youth Welfare Office, after weighing interests, in the event of serious indicators of a threat to child welfare.

This also includes awareness of the regulations in [§ 4 KKG](#). The situation should be discussed with the child or adolescent and the primary caregiver and, if necessary, work towards the primary caregiver seeking help, if this will result in the assured effective protection of the child or adolescent.

The following applies to documentation by specialised staff: All disclosures, third party statements, observed situations, findings, assessments and diagnoses resulting from a serious indicator must be documented. This documentation includes both the assessment of the existence as well as the non-existence of a threat to child welfare, and should nevertheless record which conversations were conducted with the children and adolescents and the primary caregivers, in order to offer assistance and support as well as to avert possible threats. When notifying the Youth Welfare Office of serious indicators, the primary caregiver should be informed of this and/or the reasons why the primary caregiver has not been informed must be communicated. The effective protection of the child or adolescent should not be affected thereby.

2.2.4 Awareness of diversity

Every child and every adolescent has the right to assistance and support irrespective of their gender, age, sexual orientation, skin colour, religion, nationality and mental, psychological or physical disability. Differences cannot lead to discrimination when considering a suspected threat to child welfare - the individuality of each child and adolescent must be taken into account when creating an assistance and protection plan.

2.3 Legal foundations for specialised staff

The Germany Federal Child Protection Act (Bundeskinderschutzgesetz; BKiSchG), consisting of six Articles, came into effect on January 1, 2012, as an amending law. It contains a reformation of the Child and Youth Welfare Act (SGB VIII) and a revision as the Law on Cooperation and Information in Child Protection (Gesetz zur Kooperation und Information im Kinderschutz; KKG).

As part of the SGB VIII reform, the Act to Strengthen Children and Adolescents came into force on 10.06.2021, which led, among other things, to changes in the KKG.

[KKG](#) is divided into five paragraphs:

§ 1 Child protection and shared responsibility of the state

§ 2 Informing the parents about available support with regard to child development questions

§ 3 General conditions for mandatory network structures in Child Protection

§ 4 Consulting and transferring information by persons subject to professional confidentiality in the event of a threat to child welfare

§ 5 Notifications to the youth welfare office

Discussion obligations, consulting entitlement and disclosure/notification authorisation for persons subject to professional confidentiality in the event of a threat to child welfare, are regulated in § 4 KKG, and refer to case-related cooperation.

Course of action in the event of a (suspected) threat to child welfare § 4 KKG

When a specialised professional becomes aware of indicators of a threat to child welfare while performing his/her duty, they should discuss the situation with the primary caregivers and the children and adolescents, provided that this does not endanger the child. If necessary, they should work towards the acceptance of assistance.

Specialised staff is entitled to consult an experienced specialised professional for the purpose of assessing the case of a threat to child welfare. For this purpose, the data is pseudonymised when submitted.

The specialised worker has the authority to inform the Youth Welfare Office when they consider it justified for the Youth Welfare Office to take action in order to avert a threat. Those affected should be informed of the notification provided this does not lead to endangerment of the child.

The amendment of § 4 KKG (June 2021) includes the following addition for the professional groups of the health care professions (physicians, dentists, midwives or maternity nurses or members of another health care profession that requires a state-regulated training for the exercise of the profession or the use of the professional title):

- The professional groups of the above-mentioned health care professions are to inform the Youth Welfare Office without delay if, according to their assessment, an urgent danger to the well-being of the child or adolescent requires the intervention of the Youth Welfare Office.
- Furthermore, an addition was added that the Youth Welfare Office must promptly inform the informing confidential persons whether it sees the weighty indications for the endangerment of the well-being of the child or adolescent confirmed and whether it has become active and is still active for the protection of the child or adolescent.

Professional confidentiality obligation

The legal obligation of certain occupational groups listed in § 4 Para. 1 of the KKG, not to disclose secrets entrusted to them to third parties without the consent of the affected person, is of fundamental importance particularly in the context of protecting children and adolescents, and arises from [§ 203 StGB \(German Penal Code\)](#) violation of private secrets. The confidentiality obligation protects the right to informational self-determination, the protection of the personal sphere of privacy, and protection against discrimination. In addition, knowing about the confidentiality obligation makes it easier for patients to open up to specialised staff – at the same time, the confidentiality obligation is a challenge for cooperation between specialised staff in an ongoing child protection procedure.

Specialised staff can also seek advice from a specialised professional with experience in this respect without the consent of the patient – as long as this is done in an anonymised or pseudonymised manner. If there is still a suspected threat to child welfare after this consultation, as an **authority norm in accordance with KKG**, it is possible to share serious indicators of a threat to child welfare with the Youth Welfare Office.

Exchanging information with other specialised professionals

The German Federal Child Protection Act regulates the exchange of information between persons subject to professional confidentiality and the Youth Welfare Office in cases of a suspected threat to child welfare, but not the exchange of information of persons subject to professional confidentiality amongst themselves.

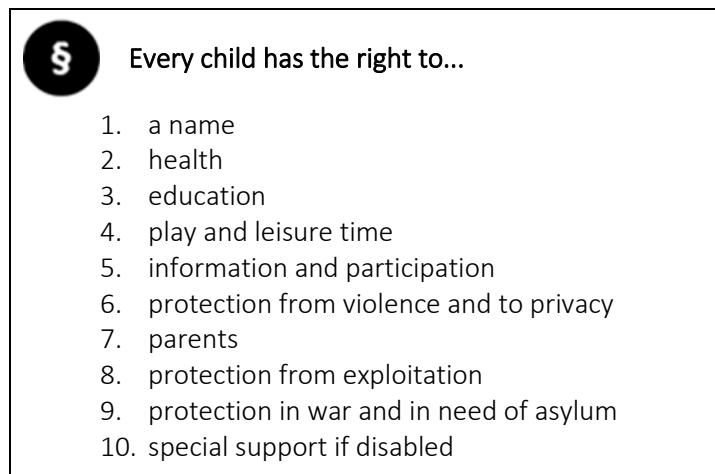
The exchange of information between specialised professionals (persons subject to professional confidentiality) is done with the consent of the children and adolescents and the primary caregiver, with exemption from the obligation of secrecy. Consultation with other specialised professionals can take place in an anonymised and pseudonymised manner.

The amendments to Section 4 of the KKG (June 2021) include an opening clause so that state law can regulate the authority for a case-related intercollegiate exchange of medical doctors.

2.4 The rights of children and adolescents

2.4 Children's rights

The Convention on the Rights of the Child is the most important international instrument for children's rights. With the exception of the United States of America, the Convention on the Rights of the Child has meanwhile been ratified on November 20, 1989, by all member states of the United Nations. There is no children's version of the edition containing 54 articles in the standard language used for treaties according to international law. UNICEF, the UN's children's rights organisation, summarises these articles in ten concise fundamental rights:



Within the Guideline at hand, the ten fundamental rights of children have been bundled into three thematically related pillars. The safeguarding of these rights of children and adolescents must be respected particularly in the context of medical child protection.

The right to be involved and to be heard

A fundamental right of children and adolescents is the participation in all decisions pertaining to them. It is particularly important to inform children and adolescents of the individual treatment steps in a medical therapy in an age appropriate manner. Children and adolescents must get an opportunity to give their informed consent to all treatment measures. The requirement for informed consent is not just the explanation of individual treatment procedures, but also the explanation of the risks involved with the treatment. The recipient of the explanation is generally the patient capable of giving consent; in the case of a minor who is unable to give consent, the primary caregiver is to be informed instead. In any case, the minor who is unable to give consent must at least be involved. If the result of the assessment is that the minor is not capable of giving consent, the consent of the primary caregiver is always required.

The right to support and care

Children and adolescents have a right to be supported and cared for by their primary caregivers and attachment figures. If the primary caregiver or attachment figure does not meet this responsibility, this is a case of neglect. The failure to create and shape a developmentally appropriate and supportive environment for children and adolescents is one of the most frequent forms of child maltreatment, yet it often remains unrecognised (Stietenroth, Nowotzin & Oberle 2016).

The right to protection

Children and youth should be protected from violence of any kind. This not only refers to the right to a violence-free upbringing, but also to protection from psychological abuse, sexual violence and crime. This makes the protection of children and adolescents a social duty, and includes both primary prevention as well as intervention in the case of a threat to child welfare that has already occurred.

2.4.2 Patient rights and the autonomy of minors

A medical examination and assessment of findings can also include a physical procedure and/or health intervention without a subsequent required treatment, which is why - as a rule - the consent of the patient is absolutely necessary. The consent to necessary measures is provided by the minor capable of giving consent or the primary caregiver.

In the context of physical or sexual abuse or neglect, disagreements between under-age patients and a primary caregiver can arise and an examination can be rejected. Consequently, the conflict between the child's or adolescent's right to self-determination and the primary caregivers' right of custody must be weighed. For this consideration, guidance from other specialised professionals should be obtained, or in the case of a suspected threat to child welfare, guidance and support from the Youth Welfare Office and/or Family Court should be obtained in consultation with the children and adolescents and the primary caregiver.

Essentially, children and adolescents should be presented with all the information about the immediate and later consequences of each measure in an age and developmentally appropriate way, so that children and adolescents can give their informed consent or refusal.

2.4.3 The capacity of minors to give consent

All recommendations for action require the consent of those affected. Consent is given by the minor capable of giving consent or by the primary caregiver.

Criteria for the minor capable of giving consent can, for example, be the ability to actively follow the explanatory discussion, ask further questions, and independently point out particulars about their own lifestyle or health. The stipulation however, of a rigid age restriction to determine the capacity to give consent, is not compatible with the necessity to assess the individual maturity of the affected child or adolescent with regard to the respective implications of the decision in each individual case. Capacity to give consent is not only to be assessed with regard to the minor's individual requirements, but also with regard to the specific medical measures. If the result of the assessment is that the minor is not capable of giving consent, the consent of the primary caregiver is always required.



Criteria to assess capacity to give consent

- understanding the type, significance, implications and risks of the medical measure (= cognitive faculty)
- weighing the benefits and risks of the medical measure and making an autonomous decision based on will (= faculty of judgement)
- controlling one's actions based on this comprehension (= faculty of control)

Excessive requirements should not be placed on the cognitive, judgement, and control faculties of the children and adolescents hereby, as the standard of comparison is the average patient and not the ideal patient.

(Lohse et al. 2018)

2.5 Rights and obligations of primary caregivers

The rights and obligations of parents stem from the German Civil Code (§ 1626 BGB, Bürgerliches Gesetzbuch). In accordance therewith, the care and upbringing is the parents' right and first and foremost obligation. The specific rights and obligations of parents as the primary caregivers stem from the sub-areas of parental care. These are divided into care and custody of the child, and management of children's property. **Care and custody of the child** includes all matters concerning the child's person:

- upbringing
- care
- supervision
- determining place of residence
- determining interaction with other persons
- accommodation associated with forcible confinement
- choice of education and profession

In contrast, **management of children's assets** includes all actions that concern the management, increase and maintenance of the child's assets. Furthermore, the primary caregiver also takes on the **legal representation** of the children. Among other things, this includes applications with administrative bodies, such as enrolling and de-registering from schools, or applying for social welfare benefits.

Furthermore, the consent of the primary caregiver is required in the event of medical treatment or a surgical procedure.

The biological mother of the child generally has custody of the child. If the mother is married, she and her husband automatically have shared custody - this also applies if he is not the biological father of the child. If the parents are not married, since 1998, it is possible for them to submit a mutual custody declaration so that both of them are entitled to custody. Since 2013, it is also possible for the biological father to apply for joint custody at Family Court without the approval of the mother.

Even if the parents live separated, both can have custody of the child. Care and custody of the child is not administered by a potential care provider of a parent, the care of the child remains with the mother or father, unless there is a guardianship for the child. In the case of single parents, a possible constellation is that one parent alone has custody.

A special regulation comes into play in the case of under-age parents. Parts of the parental custody are not carried by the under-age mother and/or under-age father, but by a guardian. In this case, the under-age parents perform all care for the child - they take on the care, upbringing, supervision and determine the place of residence of the child. In turn, the guardian of the child is responsible for all legal matters and represents the interests of the child during the process of its upbringing, impartially and independently from the parents or other specialised staff involved. Official guardianship expires when the mother attains the age of majority.

When parental care and custody is not performed

The state monitors the exercise of parental rights and obligations. If the physical, mental or psychological welfare of the child or adolescent is threatened, it is up to the parents to take measures to protect their under-age children. In this case, it is possible for them to use outside assistance, for instance such as offered by the Youth Welfare Office. However, if parents cannot or do not want to avert this threat, then the state intervenes in the form of family court measures that are necessary in order to avert the threat. In accordance with § 1666 BGB (German Civil Code), the Family Court can order measures of varying intensity to be weighed according to the principle of proportionality. Complete loss of parental custody is therefore ultima ratio.

Legal representation of children and adolescents

In daily matters, the interests of children and adolescents are represented by the primary caregiver. If they are not capable of averting significant damage to the child, an intervention into parental custody can be made in order to protect children and adolescents. If only sub-areas of custody are transferred to another person, for instance the right to determine place of residence, this is called supplementary guardianship. In the event of complete transfer of care and custody of the child with or without transfer of the management of children's property to another person, this is called legal guardianship. The transferred sub-areas of parental custody are recorded on a care provision ID with the name of the child/adolescent and the legal guardian.

In legal matters, in other words family matters procedures, the guardian ad litem (in accordance with § 158 Para. 5 FamFG) replaces the previous litigation guardian since September 1, 2009. A guardian ad litem should always be appointed for a child up to 14 years of age in child matters when necessary in order to represent the child's interests. The duty of the guardian ad litem is to determine the child's interests and to involve them as a participant in the procedure. Adolescents ages 14 and up have the

option of taking their own legal counsel and thereby involving themselves actively in the proceedings. Adolescents ages 14 and up should be made aware of this option. The costs of their own lawyer will then be settled via legal aid (cf. AG Essen 2002, ruling from June 18, 2002, filing reference 104 F 80/01 SO and Oberlandesgericht Hamburg 2017, ruling from May 2, 2017, filing reference 12 WF 70/17).

3 Introduction

3.1 Scope and purpose of the Guideline

3.1.1 Objective and issues

In the project application from November 2014, to grant an allowance from Federal Ministry of Health funds, there is a direct reference to the recommendation in the final report of the Round Table on Sexual Abuse. This reports states:

"**1. Development of overarching S3-Guidelines**, which should be compiled on the basis of the meta-analysis of existing research results on the subject of 'abuse, violence, and neglect in childhood and adolescence'. To date, guidelines only exist on the S1 and S2 level (AWMF-S2-Guideline '**Child Abuse and Neglect**', AWMF-S1-Guideline '**Neglect, Abuse, Sexual Abuse**'). However, a problem that arises during the development of S3-Guidelines is that in principle, different guidelines are required for different professional categories, the preparation of which overburdens a scientific association and/or committee of experts. Furthermore, the empirical scientific basis that the preparation of S3-Guidelines draws upon has previously been inadequate. Finally, the systematic development of corresponding S3-Guidelines is very elaborate and therefore cannot be financed by the funds of medical-scientific expert associations."

(Final report Round Table on Child Sexual Abuse 2011)

In light of this politically formulated intention, the following objectives were formulated for the Guidelines:

- Gaining certainty for specialised staff to recognise, assess and take action in possible cases of various forms of the threat to child welfare.
- Formulating recommendations for action for the diagnosis of the various forms of the threat to child welfare.
- Raising the awareness of specialised staff for the participation of children and adolescents in child protection proceedings.
- Establishing the subject of Child Protection in medicine through preparation at the highest scientific level.
- Direct influence on the medical sector and other responsible partners active in Child Protection, thanks to its multi-professional formulation. Its recommendation for the course of action in the case of suspected abuse and neglect of children can be applied in each individual case, thereby presenting a high level of value, both for those providing treatment and the children and adolescents themselves.
- Creating greater certainty of action for the individual partners by formulating recommendations that help regulate procedures in the interactions between those providing treatment (medicine, youth welfare services and education, as far as one would like education to be involved).
- Knowledge sharing with youth welfare employees: why, when and how the involvement of healthcare services can be advisable.
- Knowledge sharing with pedagogical professionals, so that they are capable of categorising what steps they can take when, with regard to youth welfare and healthcare services.

When it comes to child protection, specialised staff from various care provision areas must cooperate closely and be aware of the course of action of other child protection partners.

3.1.2 Addressees - who are these guidelines for?

The target user group of these Guidelines is primarily professionals in the healthcare sector. Furthermore, the Child Protection Guideline should present the course of action of medical child protection as well as its options and limitations in a logical manner to children and adolescents as well as to specialised staff in other care provision areas. The Child Protection Guidelines are aimed towards all Child Protection partners with regard to cooperation, involvement and interface description, and follow a fundamentally multi-professional approach. For this purpose, representatives from all addressee groups are actively involved in the development and consensus process.

3.1.3 Financing of the Guideline and disclosure of possible conflicts of interest

The creation of the Child Protection Guideline is funded with a total of 1,539,241 € with funds from the federal budget, the Child Health division of the Federal Ministry of Health (BMG), and is based on the recommendation in the final report of the Chancellor's Round Table on Sexual Abuse, at the decision of the federal government on 30/11/2011. The work of the Guidelines Office has neither been influenced by the BMG nor by the University of Bonn.

During the Guideline process, everyone involved was requested to present at least one written statement regarding possible conflicts of interest (see Annex 4 of the Guideline Report). A heartfelt thank you goes out to everyone for their exclusively voluntary work, without which, the S3-Guideline could not have been created.

3.1.4 Disclosure and handling of potential conflicts of interest

In order to protect the Guideline from the risk of being influenced by the conflicts of interest of the individual persons mandated, in addition to the obligatory obtainment and assessment of all conflict of interest statements, further protective factors were also applied:

Pluralistic composition of the guidelines group, in other words, all addressees of the Guidelines from the various care provision areas in child protection (healthcare, youth welfare services and education) have been integrated into the guidelines group at the earliest possible point in time. The highest possible level of transparency is achieved for the user through the differentiated distinction of recommendations in evidence-based recommendations for action, clinical consensus points with and without plausibility validation and statements. The three-day consensus conference was moderated from beginning to end by Prof. Kopp, Head of the AWMF-Institute for Medical Knowledge Management, with the corresponding professional competence and independence.

An overview of all existing conflicts of interests submitted by 15/10/2018, with information on participation in the constituent meeting, for access to the CGS-online Guideline portal, and on participation in the consensus conference is added as an attachment (see Annex 5 of the Guidelines Report).

3.1.5 Period of validity and updating process

The AWMF S3+ Guideline is valid until the next update. The next update is planned after five years, in other words in 2023. In the event of an urgent necessity to make an amendment, a new version or addendum can be compiled earlier. The German Society for Child Protection in Medicine (Deutsche Gesellschaft für Kinderschutz in der Medizin) is responsible for the update. Comments, references and support for the updating process are explicitly welcome and can be addressed to the office of the DGKiM:

Office of the German Society for Child Protection in Medicine (Deutsche Gesellschaft für Kinderschutz in der Medizin)

Universitätskinderklinik, Adenauerallee 119, 53113 Bonn

Telephone: 0228 287 33326

E-mail: geschaefsstelle@dgkim.de

3.2 Epidemiology in Germany

A description of the epidemiological data on abuse, neglect or threats to child welfare in Germany is challenging. On the one hand, the collected statistics are not collected in a standardised manner by the individual authorities, and on the other side, there is no standardised definition for the individual concepts/terms. Thus, the statistics on the threat to child welfare vary in the cohorts and in how data is collected.

In this section, statistics from 2017 from the Federal Statistics Office on threat assessments in accordance with § 8a SGB VIII of the Social Code (Sozialgesetzbuch, SGB), taking into care (*Inobhutnahme*), and police crime statistics reporting fatalities through murder, homicide, physical injury resulting in death, or negligent homicide, are presented. The long-term effects and socio-economic costs are also discussed.

Assessments of threats to child welfare in accordance with § 8a SGB VIII

According to the Federal Statistics Office, (Statistisches Bundesamt 2018a) in 2017, there were 143,275 legal proceedings to assess a threat to child welfare (threat assessments in accordance with § 8a SGB VIII) that were investigated by Youth Welfare Offices. The number of reports increased by 4.6% compared to 2016 (136,925).

Although more legal proceedings were reported in 2017, fewer threats to child welfare were determined than in 2016 (-0.1%)¹. For 2017, there are 45,748 known cases (55,283 including multiple mentions) where there was an acute (21,694) or latent (24,054) threat to child welfare. In 27,794 cases, indications of neglect (60.8%) were found. Indications of psychological abuse were identified in 13,559 cases (29.6%). 11,885 cases (26%) were reported where children or adolescents exhibited signs of physical abuse. Indications of sexual abuse were marginally rarer (2,045 cases; 4.5 %).

In 48,949 additional cases (+5.0%), specialised staff from the Youth Welfare Office concluded that although there was no threat to child welfare present, there was further need for assistance and support. In almost the same number of cases (48,578) neither a threat to child welfare nor a further need for assistance was found (+9.1%)¹.

Children under the age of three accounted for 23.3% of the conducted proceedings. 19.2% of the conducted proceedings were children between the ages of three and five, 22.6% were primary-school age

¹ The percentage changes compared to 2016 are indicated in the brackets.

(six to nine years of age). The percentage of proceedings conducted for the age group of 10 to 13-year olds, was 19.3%. Adolescents between the ages of 14 and 17 are involved in 15.7% of proceedings. Information about most cases was made known by police/court/public prosecutor's office (23.4%), exceedingly few were made known by counselling centres (1.1%). 6.2% of cases were made known by members of the healthcare sector, 10.1% by schools, 6% by social services/Youth Welfare Office. 20.6% of proceedings resulting in an acute or latent threat to child welfare were made known to the Youth Welfare Office by police/court/public prosecutor's office, another 12.1% by schools, 7.4% by the healthcare sector, and 8.5% by social service/Youth Welfare Office.

Being taken into care

Youth Welfare Offices are entitled and obliged to perform preliminary measures to protect children and adolescents as socio-educational assistance in acute crises or dangerous situations – the taking of children/adolescents into care. The Youth Welfare Office is entitled and obliged to take a child or adolescent into care at the request of the affected children, in the case of imminent threat to child welfare, and if it is not possible to obtain a prompt family court decision or in the event of unaccompanied entry from abroad. Until a solution is found for the problematic situation, the minors are temporarily taken into care, and housed externally, for instance in a residential care facility or foster family.

In 2017, about 61,400 measures of this kind were initiated by Youth Welfare Offices to protect children and adolescents. Every second case of a child/adolescent being taken into care could be ended after two weeks at the latest – both in the case of children (50%) as well as adolescents (49%) (Statistisches Bundesamt 2018b).

Children under the age of 14 were affected in about a third of the cases (20,300). The most frequent reason for children/adolescents being taken into care in this age group was that the primary caregivers were overburdened (49%). Protection against neglect (21%) or abuse (14%) was also reasons for initiating the protective measures.

The other two thirds (41,100) of all cases of children/adolescents being taken into care were adolescents between the ages of 14 and 18. Over half (51%) of these adolescents were taken into care as the result of unaccompanied entry from abroad. It is of importance that in the case of the adolescents, the primary caregivers were also overburdened (18%).

43% of the preliminary protective measures ended for children under 14 years of age with a return to the primary caregivers, and 32% ended with educational support in a residential care facility or in a foster family. Adolescents ages 14 to 18 on the other hand, returned back to the primary caregivers much more rarely (19%): Here, the act of being taken into care, led most frequently to educational support in a residential care facility or other form of supervised accommodation. Children/adolescents were also taken into care after other forms of in-patient assistance, for instance in a child or youth psychiatry ward or hospital. Every second case of preliminary protective measures could be ended after two weeks at the latest – both in the case of children (50%) as well as adolescents (49%).

Police crime statistics

According to police crime statistics, 162 children and adolescents in Germany died in 2017, from murder, homicide, bodily injury resulting in death, or negligent homicide (Polizeiliche Kriminalstatistik (PKS) 2018) (see Table 1).

Table 1 Fatalities of children and adolescents in Germany caused by criminal acts in 2017

		Age (year)						
		up to and under 6	6 to under 8	8 to under 10	10 to under 12	12 to under 14	14 to under 16	16 to under 18
Criminal act	Murder § 211 StGB	19	5	6	2	0	1	0
	Homicide § 212 StGB	28	1	1	0	1	1	2
	Bodily injury resulting in death §§ 227, 231 StGB	3	0	0	0	0	0	0
	Negligent homicide § 222 StGB – not in conjunction with a road traffic accident	62	6	4	3	1	2	14

StGB = Strafgesetzbuch (German Criminal Code)

General comment about the statistics

These statistics may not represent the actual number of children and adolescents that were killed in Germany in 2017, they only represent those cases that the police became aware of, and that were forwarded to the public prosecutor's office or the court after police investigations were completed. Furthermore, cases that were not reported to the Youth Welfare Office, even though a person had a serious indicator or suspicion of a threat to child welfare, are consequently also not registered.

Long-term effects of abuse and neglect of children

Abuse and neglect of children and adolescents can have both short-term as well as long-term effects. In addition to bodily injury or disability or death, the WHO (Weltgesundheitsorganisation 2018) also lists delayed cognitive development, poor performance at school, as well as dropping out of school, psychological problems, suicide attempts, increased behaviour that puts health at risk, re-victimisation and the use of violence. Other long-term effects that are closely connected to pre-existence of a threat to the welfare of a child or adolescent, are eating disorders, alcohol and drug abuse, homelessness, as well as violent and criminal behaviour (Hunter 2014). It should be noted, that not all persons affected by abuse or neglect experience the same negative effects or display the aspects listed above. Those individuals who were exposed to more than one type of maltreatment and/or longer exposure, exhibit a higher degree of trauma and worse results than those who did not experience mixed forms of neglect or abuse, and/or those who experienced it over a shorter period of time (Hunter 2014).

In addition to personal and individual consequences, there are also social effects from the abuse and neglect of children and/or adolescents, such as economic costs (for instance, taking children/adolescents into care, setting up assistance, therapies). In Germany alone, the social cost of the effects of trauma on threatened children and adolescents is estimated at 11.1 to 29.8 billion Euros per year. This corresponds to 134.84 to 363.50 € per capita (Habetha et al. 2012). These costs are similar to the data from other OECD-countries, such as Australia and Canada (Habetha et al. 2012).

3.3 The fundamentals of the methodology

3.3.1 Formulating key questions based on PICO-questions

In order to formulate key questions, a case inquiry of care provision areas was performed based on the members from individual expert associations and organisations. It was possible to describe case vignettes based on the results of the case inquiry. The case vignettes are the content-related basis for generating case-related, overarching issues, and finally, for the formulation of the PICO-questions. See the Guideline Report, Chapter 4, for more detailed information.

3.3.2 Systematic research and review of literature

A systematic guideline search was performed on the subject of abuse and neglect of children as well as systematic literature research in five databases (Pubmed, CINHAL, Embase, PsycInfo, Eric) and the Cochrane Library. The relevant literature was reviewed by two separate reviewers based on SIGN or AGREE II. See the Guidelines Report, Chapter 4, for more detailed information.

3.3.3. Formulating the recommendations and finding consensus in a structured manner

Recommendations for action were formulated during the Delphi procedure with subsequent consensus conference. Recommendations for action are both evidence-based recommendations for action as well as clinical consensus points with and without plausibility validation. All recommendations for action are assigned recommendation levels (can/should/must) and were agreed upon in a consensus at the consensus conference. A statement serves as information and is formulated without a recommendation level.

The criteria for evidence-based recommendations for action and clinical consensus points can be found in Table 32 of the Guideline Report.

3.4 Application and readability of the Guidelines

3.4.1 Recommendations for action, key recommendations and symbols

In the long version of the Guidelines, the recommendations for action are indicated as evidence-based and as a clinical consensus point; purple for an evidence-based Recommendation, and green for a Recommendation as a clinical consensus point. Statements are highlighted in grey. The reference, evidence level, and consensus level are marked respectively. Recommendations for action, clinical consensus points and statements are consecutively numbered and can be identified as **HE/KKP/S No. xx**.

The relevant source of evidence used to form the recommendations is available in the original version of the Guideline.

No. xx Evidence-based Recommendation		Consensus level (xx %)*
.....must/should/can*.....		
Source: LoE 1-4	Source et al. year	Recommendation level A/B/O*
Reference Source et al. year LoE: 1-4	Text excerpt	

*Consensus level in detail (see Chart 32 of the Guidelines Report)

No. xx Clinical Consensus Point		Consensus level (xx %)*
.....must/should/can*.....		
Source: LoE 1-4	Source et al. year	Recommendation level A/B/O*

Reference

Source et al. year

LoE: 1-4

*Consensus level in detail (see Chart 32 of the Guidelines Report)

Text excerpt

.....

No. xx Statement		Consensus level (xx %)*
.....must/should/can*.....		
(Source: LoE 1-4	Source et al. year	Statement

(Reference

Source et al. year

LoE: 1-4

*Consensus level in detail (see Table 32 of the Guideline Report)

Text excerpt)

.....



Individual recommendations for action are identified as **key recommendation** and play a significant role in the Guidelines, or present a new aspect in medical child protection.


3.4.2 Directory for figures and tables

The figures and tables included in the Guideline are listed below with full title and page reference.

- Fig. 3 WHO International Classification of Functioning, Disability and Health – correlations
- Fig. 4 Correlations of contextual factors, related to child welfare and child health
- Fig. 5 Categories to confirm abuse
- Fig. 6 Documentation, diagnostics and procedure in the event of haematomas
- Fig. 7 Course of action and clarification in the case of suspected non-accidental head injury (NAHI)
- Fig. 8 Standardised skeletal survey with indications and further diagnostic course of action
- Fig. 9 Examination, documentation and odds ratio in the case of suspected retinal haemorrhage
- Fig. 10 (chronological) sequence of possible examinations in the case of suspected sexual abuse

4 Recommendations for medical child protection


4.1 Participation of children and adolescents

No. 1 Evidence-based Recommendation	Strong consensus (100%)
Children and Adolescents must* be included as participants ¹ in the process.	
Participation ¹ has potential positive effects: It can have a therapeutic effect (incl. sense of self-respect, sense of control, improvement of the relationship between children/adolescents and specialised staff and primary caregivers/attachment figures), increase effectiveness of an intervention, allow for more personalised care and increase safety through early detection of abuse and/or neglect of children.	
¹ Participation in: The course of action in the case of a suspected threat to child welfare, communication, rules for closeness and distance, handling complaints, interaction arrangements, further residence.	
Source: Vis 2011 LoE 1-	 Recommendation level A*

No. 2 Evidence-based Recommendation	Strong consensus (100%)
Specialised staff must* actively listen to children and adolescents before making a decision for the child or the adolescent.	
Source: Cossar et al. 2014; Pölkki et al. 2012; van Bijleveld et al. 2015; Woolfson et al. 2010 LoE 3 to 4	 Recommendation level A*

No. 3 Evidence-based Recommendation	Strong consensus (100%)
Children and adolescents must* have the opportunity to express their feelings, opinions and wishes concerning treatment, accommodation, reporting to the police and concerning the subsequent steps that arise during the child protection procedure.	
Source: Woolfson et al. 2010 LoE 3	Recommendation level A*



No. 4 Evidence-based Recommendation	Strong consensus (100%)
If the wishes or requests of children and adolescents cannot be fulfilled in the child protection procedure, the reasons for this must* be explained to them clearly.	
Source: Van Bijleveld et al. 2015 LoE 4	Recommendation level A*

<p>No. 5 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>Specialised staff must* also speak with children and adolescents individually, without the primary caregiver/attachment figure.</p>	
<p>Source: Cossar et al. 2014 LoE 3</p>	<p>Recommendation level A*</p>
<p>No. 6 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>Specialised staff must* explain the content of the child protection procedure to children and adolescents in an appropriate manner, taking into account the level of development and their situation.</p>	
<p>Source: Cossar et al. 2014; Goldbeck et al. 2007 LoE 1- to 3</p>	<p> Recommendation level A*</p>
<p>No. 7 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>Child and adolescent (intermittent) participation in the case conference must* be enabled; if they do not want to participate, they must* be offered to be represented by another person (e.g. attachment figure, specialised staff member).</p>	
<p>Source: Cossar et al. 2014; Pölkki et al. 2012; Woolfson et al. 2010; Vis et al. 2011 LoE 1- to 3</p>	<p>Recommendation level A*</p>
<p>No. 8 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>During the case conference, children and adolescents must* be assisted in understanding the child protection procedure and its objectives.</p>	
<p>Source: Pölkki et al. 2012 LoE 3</p>	<p>Recommendation level A*</p>
<p>No. 9 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>A good relationship with the specialised staff is important for the participation of children and adolescents in the child protection procedure. The relationship of children and adolescents to the specialised staff should* therefore be established in an ongoing and organised manner with the necessary amount of time.</p>	
<p>Source: Pölkki et al. 2012, Van Bijleveld et al. 2015 LoE 3 to 4</p>	<p>Recommendation level B*</p>

No. 10 Evidence-based Recommendation & KKP		Consensus (94%)
<p>The wish of children and adolescents to not want to return to their parent's home must* be respected and acted upon.</p> <p>Specialised staff who become aware of this wish, must* assist the children and adolescents with establishing contact with the Youth Welfare Office. (KKP)</p>		
Source:	Rücker et al. 2015; Vis and Fossum 2013	Recommendation level
LoE 2- to 3		A*
No. 11 Evidence-based Recommendation		Consensus (94%)
<p>Adolescents who have experienced abuse and/or neglect must* be given the opportunity to be involved in an intervention (learning closeness and distance to potential perpetrators), in order to protect themselves from re-victimisation of sexual and physical abuse.</p>		
Source:	DePrince et al. 2015	Recommendation level
LoE 1-		A*

4.2 Cooperation and course of action in (medical) child protection

4.2.1 Cooperation and networking on a system level

<p>No. 12 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>Specialised staff in health care, youth welfare, legal and educational services should* cooperate in child protection with the aim of recognising, determining and ending the abuse and neglect of children (cf. § 3 KKG).</p>	
<p>Source: Social Services Office (Amt für Soziale Dienste) Bremen LoE 2++ to 4 2009; German Child Protection Agency (Deutscher Kinderschutzbund) 2014; McCarthy 2008; Paavilainen and Flinck 2017; Saunders and Goodall 1985; Schilling et al. 2014; Stanley et al. 2010</p>	<p> Recommendation level B*</p>
<p>No. 13 Evidence-based Recommendation</p>	<p>Consensus (95%)</p>
<p>The exchange of information between the cooperating partners involved from the healthcare sector, youth welfare services, the justice system and education, should* take place. In order to enable on-going collaboration, this should* be discussed, mutually arranged, and regularly checked.</p> <p>Trainings and seminars should* also take place as effective methods for motivating the various child protection professions, while qualifying them to communicate effectively and cooperate successfully.</p>	
<p>Source: Social Services Office (Amt für Soziale Dienste) Bremen LoE 2++ to 4 2009; German Child Protection Agency (Deutscher Kinderschutzbund) 2014; Gerber and Lillig 2014; Goad 2008; Saunders and Goodall 1985; Carter et al. 2006</p>	<p>Recommendation level B*</p>
<p>No. 14 Evidence-based Recommendation</p>	<p>Strong consensus (97%)</p>
<p>Cooperation partners in health care, youth welfare, legal and educational services must* respect the roles, opportunities for action and expertise of the participating professionals.</p>	
<p>Source: Social Services Office (Amt für soziale Dienste) Bremen LoE 3 to 4 2009; German Child Protection Agency (Deutscher Kinderschutzbund) 2009; Goad 2008; Saunders and Goodall 1985; Schilling and Christian 2014</p>	<p> Recommendation level A*</p>


4.2.2 Information exchange and notifying the Youth Welfare Office (§ 4 KKG)

No. 15 KKP	Consensus (90%)
<p>In the case of a suspected threat to child welfare, the course of action must* be in accordance with the Law on Cooperation and Information in Child Protection (KKG).</p>	
<p>Recommendation level A*</p>	

4.2.3 Course of action in hospitals (OPS 1-945)

OPS (Operationen- und Prozedurenschlüssel – Operation and Procedure Code) are the official German procedure classification for encoding operations, procedures and general medical measures. It is adapted from the International Classification of Procedures in Medicine (ICPM) of the World Health Organisation (WHO). OPS are also used to encode outpatient operations and procedures for remuneration in accordance with the doctor’s fee schedule. For more information about OPS, please visit the [DIMDI website](#).

The OPS 1-945 outlines the standard process in a hospital, including a multiprofessional team, when a threat to child welfare or child health is suspected and the reimbursement for this process when it takes place in a hospital. OPS 1-945 states that a fall conference should take place at the end of the process and external child protection partners, such as the child and youth welfare office, can be invited to participate in the fall conference.

No. 16 Evidence-based Recommendation	Strong consensus (100%)
<p>Where a threat to child welfare# is suspected, a multi-professional approach (e.g. child protection group in accordance with OPS 1-945) must* be taken during in-patient clarification in hospital in order to confirm or exclude neglect and/or abuse of children.</p>	
<p>Source: DAKJ & DGKiM 2016, Goessler 2011, Herbert & Bromfield 2016; annual statistics at the Zürich Children's Hospital 2000, 2005, 2016; Jaudes & Martone 1992; Krappitz 2016; McDonald 2007; Thun-Hohenstein 2005; Verocai et al. 2013; Wallace et al. 2007</p>	 <p>Recommendation level A*</p>

No. 17 Evidence-based Recommendation	Consensus (85%)
<p>A case conference should* take place as quickly as possible, in order to shorten the hospital stay.</p>	
<p>Source: Jaudes & Martone 1992; Krappitz 2016; Smith & Efron 2005</p>	<p>Recommendation level B*</p>

4.3 Signs to recognise the need for support and assistance

Part A: Characteristics of children and adolescents

In this section, situations are described that specialised staff are confronted with in their daily professional life with children and adolescents that may present indicators of a threat to child welfare.


The following course of action is endorsed in the recommendations: Observation > Conversations with children/adolescents and primary caregivers > Consulting with other specialised staff > Initiate intervention or do not initiate intervention.

4.3.1 Pediatric check-ups (Kinder-Früherkennungsuntersuchung)

No. 18 Evidence-based Recommendation		Strong consensus (100%)
Documentation in the child's medical check-up booklet should* (with the consent of the primary caregiver/attachment figure) be taken into account during the comprehensive anamnesis when determining a case of child abuse and/or neglect.		
Source:	Hoytema van Konijnenburg et al. 2013; Nothhafft 2008; Saxony State Ministry for Social Affairs and Consumer Protection 2014; Thaiss et al. 2010	Recommendation level B*
LoE 2++ to 4		

No. 19 Evidence-based Recommendation		Strong consensus (100%)
Doctors (including their staff members), that perform pediatric check-ups and other medical check-ups for children and adolescents, must* be sensitized and trained to detect abuse and/or neglect of children.		
Source:	Nothhafft 2008; Saxony State Ministry for Social Affairs and Consumer Protection 2014	Recommendation level A*
LoE 3 to 4		

4.3.2 Screening procedure for children and adolescents

No. 20 Evidence-based Recommendation	Strong consensus (100%)
<p>General screening of children and adolescents in A&E departments for abuse and/or neglect of children must* not be carried out.</p>	
<p>Source: LoE 2++ to 3</p>	<p>Bailhache et al. 2013; Hoytema van Konijnenburg et al. 2013; Louwers et al. 2010; Louwers et al. 2014; Schouten et al. 2017; Sittig et al. 2016; Verbeek et al. 2012</p>
<p> Recommendation level A*</p>	

4.3.3 Approach in the event of development and behavioural difficulties

No. 21 Evidence-based Recommendation		Consensus (82%)
<p>As observed behavioural and developmental difficulties in children and adolescents can stem from abuse and/or neglect, however it is not enough to infer a child abuse and/or neglect incident, children and adolescents with corresponding difficulties should* be spoken to in a manner appropriate to their age and level of development and asked about their well-being and their environment.</p>		
Source:	Campbell & Hibbard 2014; Hornor 2012	Recommendation level
LoE 4		B*
No. 22 Evidence-based Recommendation		Consensus (85%)
<p>In children and adolescents with observed behavioural and/or developmental difficulties, the primary caregiver and attachment figures should* be spoken to and asked:</p> <ul style="list-style-type: none"> ▪ Which behavioural and developmental difficulties have you observed? ▪ What do you think your child's level of well-being is like? ▪ How do you react to difficulties? 		
Source:	Campbell & Hibbard 2014; Hornor 2012	Recommendation level
LoE 4		B*
No. 23 KKP with plausibility validation		Consensus (79%)
<p>If there is suspicion of abuse and/or neglect of children in children and adolescents with observed behavioural and/or developmental difficulties, information stemming from various sources of the child's environment should* be compiled in order to invalidate or confirm the suspicion of abuse and/or neglect of children.</p> <p>The applicable privacy protection regulations must be taken into account hereby.</p>		
Source:	Campbell & Hibbard 2014; Hornor 2012; Maguire et al. 2015; Naughton et al. 2013; Scivoletto et al. 2010	Recommendation level
LoE 2++ to 4		B*

4.3.4 Emotional neglect and abuse

No. 24 Evidence-based Recommendation		Majority consensus (72%)
<p>In the case of suspected emotional neglect/abuse, a comprehensive anamnesis of the child or adolescent must* be performed.</p>		
Source:	Al Odhayani et al. 2013; Campbell & Hibbard 2014, Michel et al. 2014	Recommendation level A*
LoE 3 to 4		
No. 25 Evidence-based Recommendation		Strong consensus (100%)
<p>In the case of suspected emotional neglect/abuse of children and adolescents, protection and risk factors should* be critically assessed.</p> <p>The type and severity of symptoms in children and adolescents that point to possible emotional neglect/abuse are dependent on the protection and risk factors.</p>		
Source:	Al Odhayani et al. 2013; Barlow 2012, Campbell & Hibbard 2014, Hoytema van Konijnenburg et al. 2015, Michel et al. 2014	Recommendation level B*
LoE 3 to 4		
No. 26 Evidence-based Recommendation		Consensus (96%)
<p>To identify emotional neglect/abuse, the parent-child interaction¹ should* be observed and assessed in order to draw conclusions about the relationship and bond behaviour between the children/adolescents and the primary caregiver/attachment figure.</p> <p>Every interaction between the children/adolescent and the primary caregiver/attachment figure should* be used as an opportunity to assess the parent-child interaction¹.</p> <p>¹ <i>Parent-child-interaction</i>. The term "Parent" here also refers to the primary caregiver and attachment figure.</p>		
Source:	Barlow 2012, Campbell & Hibbard 2014; Egeland et al. 1983; Michel et al. 2014	Recommendation level B*
LoE 2++ to 4		

No. 2 Evidence-based Recommendation		Strong consensus (100%)
Specialised staff must* actively listen to children and adolescents before making a decision for the child or the adolescent.		
Source:	Cossar et al. 2014; Pölkki et al. 2012; Van Bijleveld et al. 2015; Woolfson et al. 2010	 Recommendation level A*
LoE 3 to 4		

No. 27 Evidence-based Recommendation		Strong consensus (100%)
Abnormalities in social behaviour, psychological symptoms and/or disorders of children and adolescents can be an indication of emotional neglect/abuse.		
These should* be observed and assessed, and used as baseline for further follow-ups, and also as a reference for examination findings that have already been made. The comprehensive complex diagnosis should* be performed by specialised professionals.		
Source:	Al Odhayani et al. 2013; Campbell & Hibbard 2014; Dubowitz et al. 2002; Dubowitz et al. 2004; Egeland et al. 1983; Maguire et al. 2015; Michel et al. 2014; Rees 2010; Taussig & Culhan 2009	Recommendation level B*
LoE 2++ to 4		

No. 28 Evidence-based Recommendation		Consensus (92%)
Declining school performance and cognitive ability of children and adolescents should* be observed and assessed, as this can be an indication of emotional neglect/abuse.		
Source:	Campbell & Hibbard 2014; Egeland & Sroufe 1981; Maguire et al. 2015; Michel et al. 2014; Naughton et al. 2013	Recommendation level B*
LoE 2++ to 4		

No. 29 Evidence-based Recommendation		Strong consensus (100%)
Failure to thrive and physical developmental delays in children and adolescents should* be taken into account, as this can be an indication of emotional neglect/abuse.		
Source:	Al Odhayani et al. 2013; Campbell & Hibbard 2014	Recommendation level B*
LoE 3 to 4		

4.3.5 Dental examinations and indicators of a threat to child welfare

No. 30 Evidence-based Recommendation	Strong consensus (100%)
<p>When treating children and adolescents with cavities, before the suspected diagnosis of (dental) neglect and after the exclusion of differential diagnosis for tooth structure defects, dentists must* discuss several factors with the child and/or adolescents and the primary caregiver/attachment figure:</p>	
<ul style="list-style-type: none"> ▪ impairment from the cavities, ▪ duration and manifestation of the cavities, ▪ knowledge and awareness of the primary caregiver/attachment figure with regard to oral health, ▪ the willingness and ability to provide dental treatment for children and adolescents, ▪ availability of and willingness for dental care. 	
<p>There is no threshold for the number of carious teeth, or no other specific mouth diseases that lead to a compulsory diagnosis of neglect.</p>	
<p>Source: Bhatia et al. 2014; Harris et al. 2009 LoE 2++</p>	<p>Recommendation level A*</p>

No. 31 Statement	Strong consensus (100%)
<p>If primary caregivers/attachment figures have been informed about the type and extent of their child's (cariou) ailments, the benefit of treatment, the specific treatment options and access to these treatment options to prevent further damages, and they deprive their children from indication-appropriate dental treatment and/or necessary oral hygiene support, this is a serious indicator of neglect.</p>	
<p>Source: American Academy of Pediatric Dentistry 2016; Bhatia et al. 2014; Harris et al. 2009 LoE 2++ to 4</p>	<p>Statement</p>

No. 32 Evidence-based Recommendation		Strong consensus (91%)
<p>In the case of suspected abuse, and/or neglect of children, dentists should* initiate the structured medical diagnostics (e.g. according to OPS 1-945).</p>		
Source: LoE 4	American Academy of Pediatric Dentistry 2016; Harris et al. 2009	Recommendation level B*

No. 33 KKP		Consensus (91%)
<p>In the case of a suspected threat to child welfare, dentists must* take action in accordance with the Law on Cooperation and Information in Child Protection (KKG).</p>		
		Recommendation level A*

No. 34 KKP with plausibility validation		Strong consensus (100%)
<p>Every oral injury should* be documented in detail. If there is a non accidental injury or doubtful anamnesis, the suspicion of abuse as the cause should* be investigated.</p> <p>If there are serious indicators for a threat to child welfare, doctors and/or dentists should* initiate the structured medical diagnostics (e.g. according to OPS 1-945) and take action in accordance with the Law on Cooperation and Information in Child Protection (KKG).</p>		
Source: LoE 2++	Maguire et al. 2007; Royal College of Paediatrics and Child Health 2014	Recommendation level B*

4.3.6 Neonatal Abstinence Syndrome

No. 35 Evidence-based Recommendation		Strong consensus (100%)
<p>Healthcare facilities that provide obstetric and/or neonatal care should* have and apply a structured procedure to identify, monitor and treat cases of neonatal abstinence syndrome. Neonatal abstinence syndrome should* be assessed with the aid of suitable measuring instruments.</p>		
Source:	AWMF S3-Guideline Methamphetamine-related Disorders 2016; Bagley et al. 2014; World Health Organization Guidelines 2014	Recommendation level B*
LoE 2++		
No. 36 Evidence-based Recommendation		Strong consensus (100%)
<p>Newborns that were constantly exposed to opioids during the pregnancy must* be hospitalised and checked for neonatal abstinence syndrome, irrespective of which opioid was taken and in what dosage by the mother.</p>		
Source:	Clery et al. 2010; Jones et al. 2010; Kaltenbach et al. 2012; World Health Organization Guidelines 2014	Recommendation level A*
LoE 1++ bis 2++		
No. 37 Evidence-based Recommendation		Consensus (91%)
<p>Newborns that were exposed to opioids and/or amphetamines during the pregnancy, should* be monitored in hospital for at least four to seven days after the birth with the aid of suitable measuring instruments.</p>		
Source:	AWMF S3-Guideline Methamphetamine-related Disorders 2016; Gaalema et al. 2012; World Health Organization Guidelines 2014	Recommendation level B*
LoE 1++		
No. 38 Evidence-based Recommendation		Strong consensus (100%)
<p>A single peak value during measurement with a screening instrument must* not be the only parameter that leads to the diagnosis of neonatal abstinence syndrome.</p>		
Source:	Jones et al. 2010; Galemaa et al. 2012	Recommendation level A*
LoE 1++		

No. 39 Evidence-based Recommendation		Strong consensus (100%)
<p>A short version of the modified Finnegan score can* be used for a newborn without serious disease progression in order to diagnose neonatal abstinence syndrome.</p>		
Source:	Maguire et al. 2013	Recommendation level
LoE 2+		0*
No. 40 Evidence-based Recommendation		Strong consensus (100%)
<p>In addition to validated measuring instruments, the measurement of the newborn's leg movement can* also assist in contributing to a diagnosis of neonatal abstinence syndrome.</p> <p>The measurement can* be done using an ordinary activity sensor that is attached to the newborn's leg.</p>		
Source:	O'Brien et al. 2010	Recommendation level
LoE 2+		0*
No. 41 KKP		Strong consensus (100%)
<p>The structured course of action to identify, monitor and treat neonatal abstinence syndrome should*, among other things, include a structured visit and interaction protocol and a multi-professional approach including a case conference with the parents and the assisting support systems.</p>		
Source:	AWMF S3-Guideline Methamphetamine-related Disorders 2016; World Health Organization Guidelines 2014	Recommendation level
		B*

Part B Characteristics of the parents*

In this section, situations are described where specialised staff may be confronted with pregnant women, parents and primary caregivers in professional situations, who attract attention because of certain features, such as stress factors or pressures.

The following stress factors/pressures may imply a need for support and assistance:

- maternal, familial or other psychosocial stress
- psychological stress
- stress from addictive behaviour.

The target group are specialised staff in the healthcare sector, who originally have a care assignment for adults and through their actions can counter an inappropriate prejudgement of their own patients as well as a possible threat to child welfare.


The assessment and consideration of the stress factors and the available resources require a professional assessment and specific information exchange with other professional staff. Here, the legal options (e.g. in accordance with § 4 KKG), a sensitive exchange to determine the needs of the patients and the relation to the child are relevant.

**Parents, primary caregiver and attachment figure*

4.3.7 Early detection of support and assistance needs

No. 42 Evidence-based Recommendation		Strong consensus (96%)
<p>During pregnancy or shortly after the birth of the child, all women must* be systematically approached by a health service provider¹ or with a questionnaire, in order to identify any possible need for support or assistance by the woman/family early on.</p>		
<p>¹e.g. gynaecologist, obstetrician, midwife, healthcare and paediatric nurse, paediatrician, psychosocial services or other persons experienced in gynaecology and obstetrics.</p>		
Source:	Carroll et al. 2005; Dennis et al. 2013; Fisch et al. 2016;	Recommendation level A*
LoE 1++ bis 2+	Fraser et al. 2000; Mejdoubi et al. 2013; Sharps et al. 2016; Taft et al. 2015	

No. 43 Evidence-based Recommendation		Consensus (93%)
<p>The conversation and/or the questionnaire for identifying a possible need for support and assistance of pregnant women and women who have recently given birth (see no. 42) must* include at least the following stress factors: maternal, psychosocial and familial stress factors.</p>		
Source:	Carroll et al. 2005; Dennis et al. 2013; Fisch et al. 2016;	Recommendation level A*
LoE 1++ to 3	Fraser et al. 2000; Grietens et al. 2004; Mejdoubi et al. 2013; Sharps et al. 2016; Taft et al. 2015	

No. 44 Evidence-based Recommendation	Strong consensus (97%)
<p>When there are indications of stress, the actual requirements for support and assistance must* be clarified in a personal conversation. Estimating and determining the need demands experience and competent, sensitive appraisal of the circumstances.</p>	
<p>Source: Fisch et al. 2016, Dennis et al. 2013, Mejdoubi et al. 2015 LoE 1++ to 2</p>	 Recommendation level A*

No. 45 Evidence-based Recommendation	Consensus (90%)
<p>If a need for assistance and support has been identified, the woman/family must* be offered appropriate support that takes both the individual difficulties, needs as well as the strengths of the woman/family into account.</p>	
<p>Support and assistance measures are offers from the areas of child and youth welfare services and the healthcare sector.</p>	
<p>Source: Easterbrook et al. 2013; Fergusson et al. 2013; Fraser et al. 2000; Green et al. 2014; McFarlane et al. 2013; Selph et al. 2013; Sharps et al. 2016 LoE 1++ bis 1-</p>	Recommendation level A*

No. 46 Evidence-based Recommendation	Strong consensus (100%)
<p>Women with indications of postpartum depression must* be offered an intervention in accordance with the guidelines¹.</p>	
<p>¹For more information, please see the S3-Guideline Unipolar Depression – National Guidelines (recommendation: 103 NEW 2015 (A, LoE Ia: Meta-analysis [1440-1442])).</p>	
<p>Source: Dennis et al. 2013 LoE 1++</p>	Recommendation level A*

No. 47 Evidence-based Recommendation	Consensus (86%)
<p>Women should* be asked about their network of relationships from when pregnancy is ascertained until at least 24 months after the birth of the child.</p>	
<p>If there are indications of domestic abuse or abuse by the partner or other persons in a woman's social environment, access to corresponding assistance should* be provided to her.</p>	
<p>Source: Sharps et al. 2016 LoE 1+</p>	Recommendation level B*

4.3.8 Information exchange - psychological wellbeing and mental health of pregnant women and parents*

*Parents, primary caregiver and attachment figure

<p>No. 48 KKP</p>	<p>Consensus (78%)</p>
<p>Healthcare service providers should* work together with the mentally ill or psychologically stressed pregnant woman and, with the consent of the woman, communicate amongst each other. The healthcare service providers should* communicate with each other and point out access to assistance to promote the health and welfare of the woman and child.</p>	
<p>Source: Austin et al. 2017; Brockington et al. 2011; Brockington et al. 2017; NICE 2017; Schofield & Sisodia 2014</p> <p>LoE 3 to 4</p>	<p>Recommendation level B*</p>
<p>No. 49 Evidence-based Recommendation</p>	<p>Consensus (94%)</p>
<p>All pregnant women and mothers of children < 24 months of age should* be asked about their psychological wellbeing and mental health at every visit to the doctor. Subsequently, action should* be taken according to Recommendation No. 48, with mentally ill pregnant women and mothers of children < 24 months of age.</p>	
<p>Source: Austin et al. 2017, Kölch 2009, NICE 2017, Schofield & Sisodia 2014</p> <p>LoE 2++ to 4</p>	<p>Recommendation level B*</p>
<p>No. 50 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>All psychiatrists and psychotherapists should*:</p> <ul style="list-style-type: none"> ▪ ask their female patients if they are pregnant ▪ ask all patients about their responsibility for a child. <p>If affected patients are under stress, action should* be taken in accordance with Recommendation No. 48.</p>	
<p>Source: Austin 2003, Austin et al. 2017, Brockington et al. 2011</p> <p>LoE 4</p>	<p>Recommendation level B*</p>

No. 51 Evidence-based Recommendation

Strong consensus (97%)

Gynaecologists and midwives should* ask pregnant women and women who have recently given birth about

- previous or current mental illnesses
- previous or current outpatient and/or inpatient treatment by a healthcare service that specialised in mental illnesses
- postnatal mental illnesses amongst first degree relatives.

If affected patients under stress, action should* be taken in accordance with Recommendation No. 48.

Source: Austin et al. 2017; NICE 2017; Schofield & Sisodia 2014

LoE 3

**Recommendation level
B***

No. 52 KKP

Strong consensus (100%)

The child of a mentally ill primary caregiver/attachment figure should* be taken into account in all the measures affecting the primary caregiver/attachment figure (assessment, care, treatment).


Source: Austin 2017

AGREE

**Recommendation level
B***

4.3.9 Children and adolescents of addiction-afflicted parents*

*Parents, primary caregiver and attachment figure

No. 53 Evidence-based Recommendation		Strong consensus (100%)
<p>Where an addictive disorder of the primary carer/attachment figures is suspected, children and adolescents should* be given the opportunity to express their own opinion of their well-being; the topic of the addictive disorder should be openly addressed in the conversation.</p>		
Source:	Kroll et al. 2004; Simons et al. 2008; Staton-Tindall et al. 2013	 Recommendation level B*
LoE 2++ to 3		

No. 54 Evidence-based Recommendation		Strong consensus (100%)
<p>If the addiction of the primary caregiver has been established¹, specialised staff must* accompany children and adolescents and/or the addicted person in identifying, documenting and assessing possible indicators such as risk factors (e.g. domestic violence, delinquency, poverty or lack of parental care).</p>		
<p>In the case of a suspected threat to child welfare, the course of action must be in accordance with the Law on Cooperation and Information in Child Protection (KKG). (KKP)</p>		
<p>¹In addition to the primary caregiver, it can also be an attachment figure that lives in the same household as the children and adolescents.</p>		
Source:	Lawson et al. 2001; Simons et al. 2008; Vanderploeg et al. 2007	Recommendation level A*
LoE 3		

No. 55 Evidence-based Recommendation

Strong consensus (100%)

In cases of children and adolescents whose primary caregivers¹ have an addictive disorder, planned and introduced measures should* be discussed with the families and all those involved in the case, so that neglect and/or abuse can be avoided or ended by adequate assistance measures for the children and adolescents, the addicted person and the family.

This applies to agreements on the (process) results of:

- Estimates of the children's or adolescents', the addicted person's and the whole family's need for assistance
- Appraisal of the children's and adolescents' well-being or estimate of the threat to child welfare
 - Therapies for children and adolescents and/or primary care givers¹ (including obstacles and motivators)
 - Legal proceedings (e.g. right of custody and right to determine the place of residence)
 - Relevant measures introduced

¹As well as the primary care giver, this may also refer to an attachment figure who lives in the same household as the children and adolescents.

Source: Bruns et al. 2012; Green et al. 2008; Hines et al. 2008;
LoE 1+ to 4 Kroll et al. 2004; Ryan et al. 2006; Smith et al. 2006;
 Stover et al. 2015; Wilson et al. 2008



Recommendation level
B*

4.3.10 Screening of adults in the emergency room

No. 56 Evidence-based Recommendation

Strong consensus (100%)

When adults attend A&E due to domestic violence and/or a suicide attempt or a psychological decompensation and/or substance intoxication the question must* be asked as part of patient screening whether the patient is responsible for an under-age child or children, in order to recognise possible abuse and/or neglect of children. In this case the hospital's social service must* be informed.

Source: Diderich et al. 2013; Diderich et al. 2014; Diderich et al.
LoE 2++ bis 2+ 2015; H. v. Konijnenburg et al. 2015



Recommendation level
A*

4.4 Diagnostic methods to assess abuse

4.4.1 Structured questioning of children and adolescents

No. 57 KKP	Consensus (94%)
<p>57a: In children and adolescents suspected of being subjected to child abuse and/or neglect, the initial statement of the children and adolescents should* be recorded and, if applicable, specified by a few questions according to the principles of the NICHD protocol, as part of a multi-professional diagnosis as promptly as possible from the time of the incident or last assault.</p> <p>57b: Children and adolescents suspected of being subjected to child abuse and/or neglect, should* be offered a forensic interview, in consultation with law enforcement bodies and/or family law jurisdiction, and with the consent of the children and adolescents and primary caregiver/legal guardian, if the statement of the children and adolescents appears to require clarification with regard to child abuse and/or neglect.</p>	
<p>Source: Herbert & Bromfield 2016; Newlin et al. 2015 LoE 2++ to 4</p>	<p>Recommendation level B*</p>

No. 58 Evidence-based Recommendation	Strong consensus (97%)
<p>The forensic interview should* be performed in a structured manner with the aid of evaluated protocols. An example of an evaluated protocol of this kind is the revised NICHD-protocol, which is also available in German.</p>	
<p>Source: Anderson et al. 2014; Benia et al. 2015; Herschkowitz et al. 2014; Lewry et al. 2015 LoE 2++ to 3</p>	<p>Recommendation level B*</p>

No. 59 Evidence-based Recommendation	Strong consensus (100%)
<p>The forensic interview should* be documented permanently by means of the interviewers taking notes, as well as audio and video recordings. This requires the informed consent of the children and adolescents.</p>	
<p>Source: Newlin et al. 2015 LoE 4</p>	<p>Recommendation level B*</p>

No. 60 Evidence-based Recommendation

Strong consensus (100%)

The interviewers should* be trained and guided in performing a forensic interview. In preparation, possible obstacles, case-specific concerns and interview strategies should* be discussed in a multi-disciplinary manner. As a follow-up, a possibility to give feedback should* be provided.

Source: Newlin et al. 2015; Lamb et al. 2002a; Lamb et al. 2002b
LoE 3 to 4

Recommendation level B*

No. 61 Evidence-based Recommendation

Strong consensus (100%)

The interviewers must* encourage the child's or adolescent's memory by asking open questions. The interviewers must* avoid influencing the child or adolescent or asking questions in a suggestive manner.

Source: Anderson et al. 2014; Lewry et al. 2015; Newlin et al. 2015;
LoE 3 to 4 Orbach & Lamb 2001

Recommendation level A*

Dissenting opinion "Forensic interview, and/or structured questioning"

Employees who come into contact with children and adolescents and possibly with their first statements regarding the threat to child welfare, must be trained. Knowledge about how to perform an interview and documentation (also with regard to criminal aspects) is necessary. Forensic interviews can be helpful here in addition. However, the current data situation does not allow for a general preference for these interviews. Furthermore, particularities in the care system in Germany as well as in the legal system must be observed in the transferability.

In most cases, it is not a matter of criminal charges, it is a matter of assistance. By analogy to the much discussed obligatory home visit in the case of suspected threat to child welfare by Youth Welfare Services as part of the Germany Federal Child Protection Act, we see the risk of a mechanistic approach that does not correspond with the differentiated needs of minors in the situation, and that has no added value with regard to child protection. Furthermore, it is questionable whether a certified tool, which might be pursuing economic interests, can be recommended at this juncture.

**German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy
&
the National Association of Leading Clinicians
for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy**

in agreement with

**the Independent Federal Government Commissioner for Questions regarding Sexual Child Abuse
&
the Federal Conference for Educational Counselling e.V.**

The German Society for Psychotraumatology can not yet support the request for a virtually obligatory introduction of a forensic interview at this time. From our perspective, this still requires a considerable amount of research, on the one hand with regard to the transferability of Anglo-American tools of this kind into practice in German-speaking regions, and also - and this seems to be the more important point for us - what effects the introduction of a forensic interview has on the awareness and sensitivity of processing sexual abuse in practice, in order to be able to make such a strong and far-reaching recommendation.

The background of this negative vote is that, from our point of view, two central objectives at least partially contradict each other. On the one hand, the important penal objective of obtaining statements that are as good as possible for use in court, and on the other hand, the objective of creating awareness of this subject matter for the wide-ranging therapeutic field. The fundamental concept of increasing the usability of statements in court, appears to me to be very important. Before stating this in such a far-reaching recommendation, one should perform truly large scale fieldwork and also evaluate the effects of such a recommendation for dealing with the subject, and whether this could also lead to affected persons receiving less specific therapeutic assistance.

German Society for Psychotraumatology

4.4.2 Diagnostics in the case of suspected physical abuse

Fig. 11 Categories to confirm abuse

Categories to confirm abuse	
Category	
1	Confirmation of abuse by means of a case conference, or civil or criminal proceedings, or admittance by the perpetrator
2	Confirmation of abuse by a multi-disciplinary team based on specific findings
3	Specific findings for abuse
4	Allegation of abuse
5	Suspicion of abuse

At least two specialised professionals substantiate the suspicion of abuse and provide the **indication** for further diagnostics:

- targeted anamnesis inquiry
- physical and/or also anogenital examination
- imaging diagnostics
- funduscopy
- laboratory tests.

Categories 1 & 2 confirm the diagnosis of abuse. In category 3, a specific finding of abuse is examined.

Purpose of the recommendations

- During diagnostics for abuse, specialised staff assist
- in recording findings in a structured manner, and performing special diagnostics
- naming suspicious and indicative findings for abuse
- inter-disciplinary and multi-disciplinary clarification

AIMS

- ▶ Objectify maltreatment indicators
- ▶ Establish (developmental) prognosis
- ▶ Communicate assessment securely

No. 62 Evidence-based Recommendation

Strong consensus (100%)

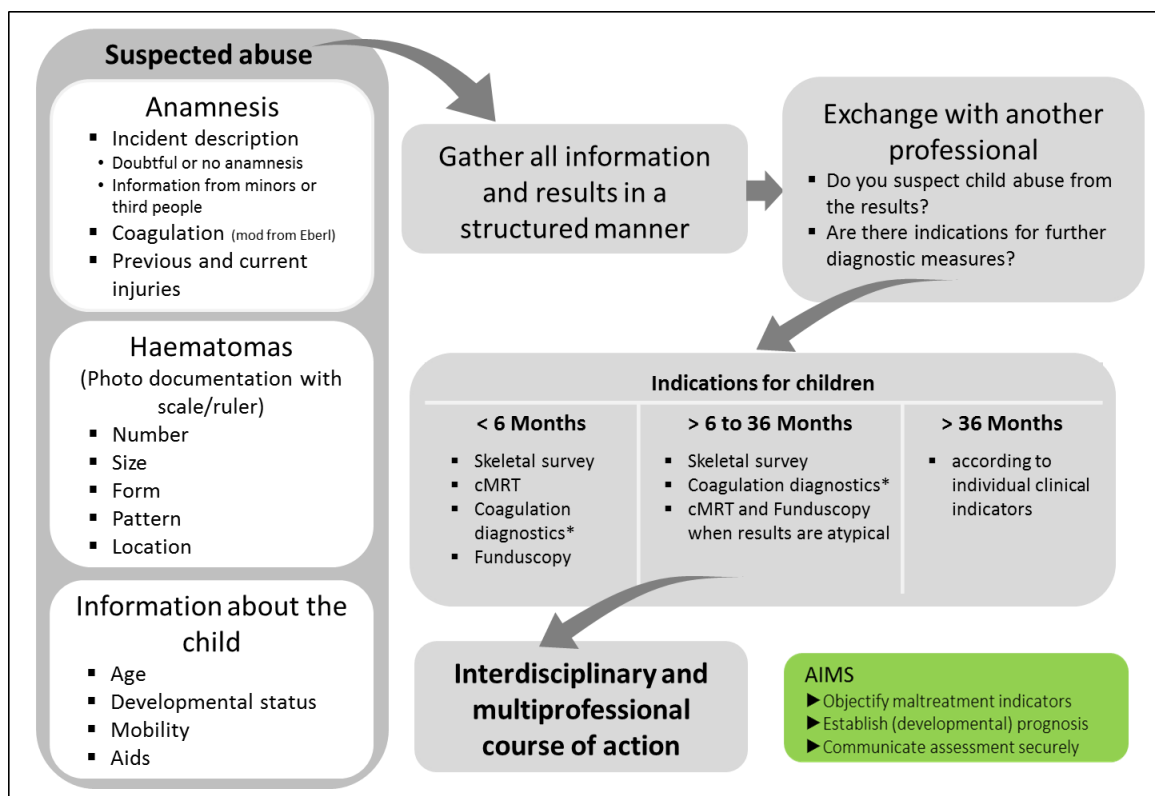
In the event of suspected physical abuse, questions about the development of haematomas or other injuries with unclear origins should*, among others, be asked in the comprehensive anamnesis.

Source: Thorpe et al. 2014
LoE 2+

Recommendation level
B*

4.4.3 Haematomas and thermal injuries

Fig. 12 Documentation, diagnostics and procedure in the event of haematomas



*Coagulation anamnesis and conducting a step-by-step lab

<ul style="list-style-type: none"> INR aPTT Fibrinogen Haemogram with leukocyte differentiation 	<p>→</p> <p>if there are abnormalities in the laboratory and/or in the event of missing non-accidental injuries</p>	<p>→</p> <p>Extend laboratory diagnostics (if necessary, in consultation with haemostaseologists)</p>	<p>→</p> <ul style="list-style-type: none"> Individual factors (Factor XIII, Factors VIII & IX for boys) Willebrand Diagnostics (VWF-antigen, VWF-collagen bonding activity, VWF-activity, blood type) Platelet function (see AWMF-Guideline on diagnosis of thrombocytopathies)
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Haematomas on children suspected of being caused by abuse

- shaped haematomas
- haematomas that appear in clusters
- haematomas that appear in combination with fractures, burns, intracranial bleeding or unclear injuries
- every haematoma on a pre-mobile infant
- haematomas in the area of the ears, neck, hands, calves and genitals in all age groups
- haematomas in the area of the front thorax, abdomen, and buttocks of mobile infants and toddlers

No. 63 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with haematomas, first the number, localisation and appearance thereof must* be assessed with regard to age, level of development and mobility.

Children and adolescents with haematomas suspected of being caused by abuse must* undergo further diagnostics.

Haematomas suspected of being caused by abuse include shaped haematomas, haematomas that appear in clusters, and haematomas that appear in combination with fractures, burns, intracranial bleeding or unclear injuries.

In addition, these include:

- haematomas in the area of the ears, neck, hands, calves and genitals in all age groups
- haematomas in the area of the front thorax, abdomen, and buttocks of mobile infants and toddlers
- every haematoma on a pre-mobile infant.
- In the event of missing or unclear formation mechanism of the haematoma, the personal and family anamnesis must* be examined with regard to a possible coagulation disorder.
- If there is no reference to a coagulation disorder and atypical haematomas, the suspicion of physical abuse must* be investigated.

The exclusion and/or confirmation of physical abuse must* be made in a multi-disciplinary team (e.g. child protection group, see Recommendation No. 16).

Source: Anderst 2013; Harper et al. 2014; Kemp et al. 2014b; Maguire et al. 2013; Maguire et al. 2005

Recommendation level A*

No. 64 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with haematomas suspected of being caused by abuse (see Recommendation No. 63), the following must* be photographed and/or documented:

- Number, size, and distribution pattern of the haematomas (overview, section, and detail photography with the aid of a photomacrographic ruler)
- Mobility of the child (pre-mobile, early mobile, or mobile)
- Information about the children's and adolescent's special needs.

Source: Anderst et al. 2013; Collins et al. 2016; Kemp et al. 2015; Maguire et al. 2005

Recommendation level A*

No. 65 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with special needs and haematomas suspected of being caused by abuse, the following should* also be documented in addition to Recommendation No. 64:

1. Mobility status (e.g. wheelchair-bound or confined to a bed)
2. Muscle tone
3. Provision of therapeutic aids
4. Cognitive abilities.

Source: Goldberg et al. 2009; Maguire et al. 2005; Maguire et al. 2013
LoE 2++ bis 2-

Recommendation level B*

No. 66 Evidence-based Recommendation

Strong consensus (100%)

A blood clotting disorder must* be ruled out in children < 6 months of age with haematomas suspected of being caused by abuse as well as an examination for occult injuries based on a skeletal survey (see Recommendation No. 83 & No. 85) and a magnetic resonance tomography (cMRT) of the skull including a diffusion-weighted sequence performed (see Recommendation No. 73).

Source: Harper et al. 2014; Kemp et al. 2014b
LoE 2+

Recommendation level A*

Supplemented by the Association for Paediatric Radiology e.V.

Tip for efficient practical procedure in the daily routine: Planning of the examination and positioning the child for MRT of skull and spine. In the case of normal intracranial findings, the examination of the spine does not have to be done. This decision must be made by an experienced examiner.

No. 67 Evidence-based Recommendation

Strong consensus (100%)

In children > 6 to 36 months of age with haematomas suspected of being caused by abuse and founded suspicion of abuse, blood clotting disorders must* be ruled out and a search performed for further occult injuries based on a skeletal survey (see Recommendation No. 83 & No. 85).

Source: Kemp et al. 2014b
LoE 2+

Recommendation level A*

No. 68 KKP

Strong consensus (100%)

In children and adolescents with atypical haematomas, a standardised blood clotting anamnesis¹ must* be examined; if there are references to a blood clotting disorder, a haemostaseological reference should be consulted and the further clotting diagnostics reconciled.

¹e.g. standardised anamnesis examination, modified according to Eberl

Third party anamnesis of the child:

Does your child have frequent nosebleeds for no apparent reason?

Do bruises appear on your child frequently, even in unusual places?

Have you detected bleeding of the gums without any apparent reason?

Has your child ever had surgery?

Did your child experience long-lasting or continuous bleeding during the dentition stage or when teeth were pulled?

Has your child ever received a blood transfusion or blood products?

Has your child taken pain medication, such as Aspirin, in the last few days?

Does your child receive any medication, such as valproate, Marcumar, ...?

Does your child have an underlying disease that you are aware of, such as a liver or kidney disease?

Family anamnesis (mother and father separately)

Do you have frequent nosebleeds, even for no apparent reason?

Do you get bruises frequently, even without hitting against anything?

Have you detected that your gums bleed for no apparent reason?

Do you have the impression that you bleed longer when you have cut yourself (e.g. shaving)?

Did you every experience long-lasting or increased secondary bleeding after surgery?

Did you every experience long-lasting or increased secondary bleeding after having a tooth pulled?

Have you ever received a blood transfusion or blood products?

Were there ever cases of an increased tendency to bleed in your family, e.g. even after operations or births?

Additional questions for the mother

Would you say that your menstrual period is or was strong or long-lasting?

Did you experience increased bleeding during or after giving birth to a child?

Cave: In addition, questions must be asked about already known bleeding disorders and previous examinations.

Source: Jackson et al. 2015

LoE 3

Recommendation level

A*

No. 69 KKP with plausibility validation

Consensus (90%)

The explanation for injury must* be documented for every thermal injury of children and adolescents.

If the explanation for injury does not match the injury pattern, the assumption must* be that it is an unexplained thermal injury (suspicion of child abuse).

In this case, in addition to the medical diagnostics (e.g. according to OPS 1-945) the Youth Welfare Office must* also be notified and if necessary, the police called in order to initiate the necessary investigation into the actual events of the incident.

Source: Kemp et al. 2014a; Maguire et al. 2008; Peck et al. 2002

LoE 2++ to 3

Recommendation level A*

No. 70 Evidence-based Recommendation

Consensus (82%)

In the case of children and adolescents with unexplained thermal injuries (Recommendation No. 69) the following questions must* be answered:

- Are there other injuries (e.g. fractures)?
- Is there knowledge of previous injuries or abuse?
- Is domestic violence present?
- Are siblings made responsible for the injury?

Questions with positive answers consolidate the suspicion of abuse.

Source: Maguire et al. 2008

LoE 2++

Recommendation level A*

No. 71 KKP with plausibility validation

Consensus (93%)

The question of neglect should* be assessed and clarified in a multi-disciplinary manner for every thermal injury as the cause of scalding/burning (e.g. according to OPS 1-945) in children and adolescents.

In the case of a suspected threat to child welfare, the course of action must be in accordance with the Law on Cooperation and Information in Child Protection (KKG).

Source: Chester et al. 2006; Maguire et al. 2008

LoE 2++ to 3

Recommendation level B*

4.4.4. Imaging diagnostics and non accidental injuries

No. 72 Statement	
In the event of lack of evidence of rib fractures using standardised skeletal survey and persistent suspicion of abuse, performing a skeletal scintigraphy can help detect rib fractures.	
Source:	Kemp et al. 2006; RCPCH. 2017d
LoE 2++	Statement

Fig. 13 Course of action and clarification in the case of suspected non-accidental head injury (NAHI)

Diagnostics in the event of suspected NAHI								
Anamnesis	<p>Structured anamnesis with recording of:</p> <ul style="list-style-type: none"> ▪ what actually happened ▪ the personal anamnesis (previous illnesses or injuries) ▪ the family and clotting anamnesis ▪ the psycho-social stress factors 							
body status	<ul style="list-style-type: none"> ▪ careful physical examination with photo documentation 							
imaging diagnostics	<ul style="list-style-type: none"> ▪ magnetic resonance tomography (brain and spinal cord channel) ▪ skeletal survey 							
examination of the eyes	<ul style="list-style-type: none"> ▪ documented, structured funduscopy 							
Laboratory	<ul style="list-style-type: none"> ▪ coagulation anamnesis and conducting a step-by-step lab <table border="0" style="margin-left: 20px;"> <tr> <td style="vertical-align: top;"> <p>INR, aPTT, fibrinogen, haemogram with leukocyte differentiation</p> </td> <td style="vertical-align: middle; text-align: center;">➔</td> <td style="vertical-align: top;"> <p>if there are abnormalities in the laboratory and/or in the event of missing non-accidental injuries</p> </td> <td style="vertical-align: middle; text-align: center;">➔</td> <td style="vertical-align: top;"> <p>Extend laboratory diagnostics (if necessary, in consultation with haemostase-ologists)</p> </td> <td style="vertical-align: middle; text-align: center;">➔</td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> • Individual factors (Factor XIII, Factors VIII & IX for boys) • Willebrand Diagnostics (VWF-antigen, VWF-collagen bonding activity, VWF-activity, blood type) • Platelet function (see AWMF-Guideline on diagnosis of thrombocytopathies) </td> </tr> </table> ▪ Transaminases, pancreatic enzyme, creatine kinase, creatinine ▪ Urine for organic acids ▪ Drug screening in urine 	<p>INR, aPTT, fibrinogen, haemogram with leukocyte differentiation</p>	➔	<p>if there are abnormalities in the laboratory and/or in the event of missing non-accidental injuries</p>	➔	<p>Extend laboratory diagnostics (if necessary, in consultation with haemostase-ologists)</p>	➔	<ul style="list-style-type: none"> • Individual factors (Factor XIII, Factors VIII & IX for boys) • Willebrand Diagnostics (VWF-antigen, VWF-collagen bonding activity, VWF-activity, blood type) • Platelet function (see AWMF-Guideline on diagnosis of thrombocytopathies)
<p>INR, aPTT, fibrinogen, haemogram with leukocyte differentiation</p>	➔	<p>if there are abnormalities in the laboratory and/or in the event of missing non-accidental injuries</p>	➔	<p>Extend laboratory diagnostics (if necessary, in consultation with haemostase-ologists)</p>	➔	<ul style="list-style-type: none"> • Individual factors (Factor XIII, Factors VIII & IX for boys) • Willebrand Diagnostics (VWF-antigen, VWF-collagen bonding activity, VWF-activity, blood type) • Platelet function (see AWMF-Guideline on diagnosis of thrombocytopathies) 		

Cave:

A cranial computer tomography and/or a sonography of the skull cannot replace the MRT imaging. Lumbar puncture is not included in the diagnostics in the case of suspected NAHI. If a diagnostic lumbar puncture is indicated, for instance due to a primary suspicion of sepsis, meningitis or encephalitis, the age of bleeding should be cytologically determined in the cerebrospinal fluid.

AIMS

- ▶ Objectify maltreatment indicators
- ▶ Establish (developmental) prognosis
- ▶ Communicate assessment securely

Non accidental head injury (NAHI)

No. 73 Evidence-based Recommendation	Strong consensus (100%)
<p>If it is suspected that a head injury has been caused by abuse and the child is not in a clinically life-threatening situation, a magnetic resonance tomography (MRT) of the skull including a diffusion-weighted sequence¹ must* be performed. If further signs of abuse arise during the examination, an MRT of the spine must* also be performed.</p> <p>¹and susceptibility-weighted sequence (SWI): There is only limited evidence for this purpose.</p>	
<p>Source: Kemp et al. 2010, Maguire et al. 2009 LoE 2++ to 3</p>	<p>Recommendation level A*</p>
<p>Supplemented by the Association for Paediatric Radiology e.V. <u>Tip for efficient practical procedure in the daily routine:</u> Planning of the examination and positioning the child for MRT of skull and spine. In the case of normal intracranial findings, the examination of the spine does not have to be done. This decision must be made by an experienced examiner.</p>	

No. 74 Evidence-based Recommendation	Strong consensus (100%)
<p>If it is suspected that a head injury has been caused by abuse and the child is in a life-threatening situation, a cranial computer tomography scan (cCT) must* be performed.</p>	
<p>Source: Kemp et al. 2009; RCPCH. 2017b LoE 2++</p>	<p>Recommendation level A*</p>

No. 75 Evidence-based Recommendation	Strong consensus (97%)
<p>If the cranial computer tomography (cCT) of the child reveals indications of a head injury caused by abuse, a magnetic resonance tomography (MRT) of the skull including a diffusion-weighted sequence¹ and an MRT of the spine must* be performed.</p> <p>¹and susceptibility-weighted sequence (SWI): There is only limited evidence for this purpose.</p>	
<p>Source: Kemp et al. 2009, Kemp et al. 2010, Kemp et al. 2011, Piteau et al. 2012; RCPCH. 2017b LoE 2++ to 3</p>	<p>Recommendation level A*</p>

No. 76 Evidence-based Recommendation	Strong consensus (100%)
<p>An ultrasound examination of the head must* not be the only diagnostic examination consulted in the case of a head injury suspected of having been caused by abuse.</p>	
<p>Source: RCPCH. 2017b LoE 2++</p>	<p>Recommendation level A*</p>

No. 77 Evidence-based Recommendation	Strong consensus (100%)
<p>In the case of a child < 24 months of age with intracranial injury and skull fracture, and lack of witnessed accidental injury or doubtful anamnesis, suspicion of abuse must* be investigated with further structured diagnostics.</p>	
<p>Source: RCPCH. 2017b LoE 2++</p>	<p>Recommendation level A*</p>

No. 78 Evidence-based Recommendation	Strong consensus (100%)
<p>An ultrasound examination of the skull can be performed as diagnostics if there is suspicion of a skull fracture.</p>	
<p>Source: Burke et al. 2014, RCPCH. 2017b LoE 2++ to 3</p>	<p>Recommendation level 0*</p>

No. 79 Evidence-based Recommendation	Strong consensus (100%)
<p>In the case of children with subdural haemorrhage, in particular with several subdural haemorrhages and/or with signs of a cerebral diffusion impairment and/or a cerebral edema in the imaging of the central nervous system and with lack of witnessed accidental injury or doubtful anamnesis, suspicion of abuse must* be investigated with further structured diagnostics.</p>	
<p>In the case of children < 12 months of age with non accidental head injury, these injuries are serious and are associated with a high mortality rate.</p>	
<p>Source: Piteau et al. 2012, Roach et al. 2014, RCPCH. 2017b LoE 2++</p>	<p>Recommendation level A*</p>

No. 80 Evidence-based Recommendation

Strong consensus (100%)

In children < 24 months of age with a head injury suspected of being caused by abuse, a thorough ophthalmological examination (dilated pupils and indirect funduscopy) must* be performed.

Source: Maguire et al. 2013, RCPCH. 2017b

LoE 2++

Recommendation level

A*

No. 81 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with a combination of two or more of the following symptoms:

- non accidental injury and doubtful anamnesis
- subdural haemorrhage
- cerebral diffusion impairment
- skull fracture with or without intracranial injury
- rib fractures
- (metaphyseal) fracture/s of the long bones
- cerebral seizure
- apnoea

the suspicion of head injury caused by abuse must* be investigated.

If there is a non accidental injury or a doubtful anamnesis or no other illness, in addition to an examination of the eyes, the corresponding radiological examination must* also be performed.

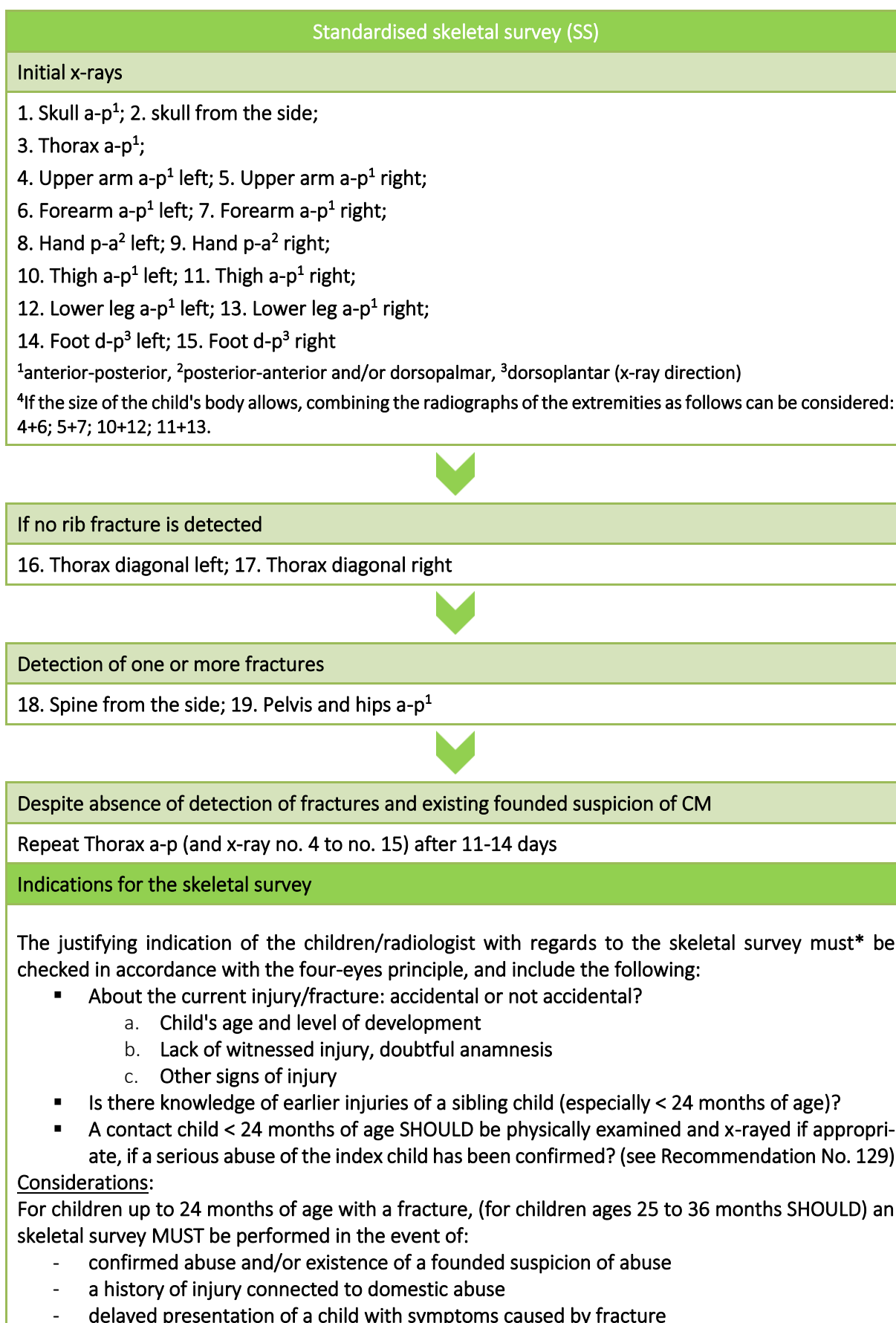
Source: Piteau et al. 2012; RCPCH. 2017b; RCPCH. 2017d

LoE 2++

Recommendation level

A*

Fig. 14 Standardised skeletal survey with indications and further diagnostic course of action



- detection of additional injuries during the physical examination (such as haematomas, scalding/burns suspected of being caused by abuse)
- doubtful or missing anamnesis.

Exceptions:

In the event of the occurrence of forearm and lower leg fractures of mobile children (> 9-12 months of age) with missing anamnesis or also declared falls, accidental injury should be considered, for instance a toddler's fracture.

Course of action in the event of lack of witnessed accidental injury or doubtful anamnesis for children with fractures:

Type of injury	EG*	Age of child:	Diagnostic and interdisciplinary clarification
Multiple fractures	A		skeletal survey in the event of abnormal findings in SS: Funduscopy, cMRT, spinal MRT Funduscopy, cMRT, spinal MRT Funduscopy, cMRT (in the event of abnormal findings in cMRT: spinal MRT) In the event of abnormal findings in SS: Funduscopy, cMRT (in the event of abnormal findings in cMRT: spinal MRT)
Skull fracture with intracranial injury	A	up to 24 months	
Complex Skull fracture/s	B	< 48 months	
Rib fracture/s*	A	< 18 months	
	B	< 48 months	
Metaphyseal fractures*	A	< 18 months	
Atypical haematoma	A	< 6 months 6 - 36 months	
Humerus fracture*	A	< 18 months	
Femur fracture*	A	< 18 months	
Forearm fracture	B	< 18 months	
Lower leg fracture	B	< 18 months	

*Recommendation level

Note:

The indication for the diagnostics should be considered in each individual case. There is evidence for the age groups listed.

There is no evidence for performing imaging procedures of the abdomen.

Practical tips for performing the spinal MRT, see RfA No. 66 & 73

AIMS

- ▶ Objectify maltreatment indicators
- ▶ Establish (developmental) prognosis
- ▶ Communicate assessment securely

Skeletal survey (SS)

No. 82 Evidence-based Recommendation

Strong consensus (100%)

A comprehensive and standardised skeletal survey must* take place if there is good reason to suspect abuse of a child.

The following individual images must* be taken:

1. skull a-p1; 2. skull lateral view; 3. thorax a-p1; 4. humerus a-p1 left; 5. humerus a-p1 right; 6. forearm a-p1 left; 7. forearm a-p1 right; 8. hand p-a2 left; 9. hand p-a2 right; 10. femur a-p1 left; 11. femur a-p1 right; 12. tibia/fibula a-p1 left; 13. tibia/fibula a-p1 right; 14. foot d-p3 left; 15. foot d-p3 right.

Further x-rays must* be taken, depending on the findings in the individual images listed above.

A. If no rib fractures were detected, then 16. Thorax oblique view left and 17. Thorax oblique view right must* be taken.

B. If one or more fractures have been detected, then 18. spine lateral view and 19. Pelvic girdle a-p¹ must be taken.

¹anterior-posterior, ²posterior-anterior and/or dorsopalmar, ³dorsoplantar (x-ray direction)

Notes on performing the radiographs

If the child's size permits, x-rays of the extremities may be combined as follows: 4+6; 5+7; 10+12; 11+13. (Strong consensus, 97%)

Source: Jha et al. 2013; Kleinman et al. 2013; Maguire et al. 2013; Marine et al. 2014; Phillips et al. 2015; RCPCH. 2017d

LoE 2++



Recommendation level A*

Supplemented by the Association for Paediatric Radiology e.V.

- If there is a cranial spiral-CT with thin layers or verification of a skull fracture in the cCT, foregoing x-rays of the skull can be discussed.
- Depending on the resulting findings, such as a questionable fracture of the extremities in one layer and, in the event of verification of fracture, a radiograph in the second layer is required.
- Protection of the gonads is not used for girls when taking x-rays of the pelvis.

No. 83 Evidence-based Recommendation

Strong consensus (97%)

A standardised skeletal survey to give evidence of occult fractures must* be carried out on all children < 24 months, if there is a suspicion of abuse or substantiated abuse. This includes in particular children with thermal injuries or verified fractures or head injury caused by abuse.

Source: RCPCH. 2017b; RCPCH. 2017d
LoE 2++



**Recommendation level
A***

No. 84 Evidence-based Recommendation

Strong consensus (100%)

If there is a lack of verification of fractures in the initial standardised skeletal survey, and clinical indications of abuse still persist, the skeletal survey should* (x-ray no. 3-15) be repeated after 11-14 days.

Source: Maguire et al. 2013; Powell-Doherty et al. 2017; RCPCH.
LoE 2++ bis 2017d
2+

**Recommendation level
B***

No. 85 KKP with plausibility validation

Strong consensus (100%)

A standardised skeletal survey to verify occult fractures should* be performed for children > 25 to 36 months of age, if there is a suspicion of abuse or substantiated abuse.

This particularly includes children with thermal injuries or with verified fractures or head injury caused by abuse.

Source: RCPCH. 2017d
LoE 2++

**Recommendation level
B***

No. 86 Evidence-based Recommendation

Consensus (90%)

A standardised skeletal survey to verify occult fractures should* be performed in siblings < 24 months of age of a (physically) abused child or other children < 24 months of age living in the same household.

Source: Maguire et al. 2013; RCPCH. 2017d
LoE 2++

**Recommendation level
B***

Supplemented by the Association for Paediatric Radiology e.V.

When examining the sibling child < 24 months of age, it is also advisable to perform a cranial ultrasound regarding the question of extended subdural space. The transfontanellar and transcranial cranial ultrasound should* be performed, and in particular, a search for chronic subdural haematomas or hygromas.

No. 87 Evidence-based Recommendation

Strong consensus (97%)

A standardised skeletal survey to detect occult fractures must* be performed on other children born at the same time (e.g. twin) of a (physically) abused child < 24 months of age.

Source: Maguire et al. 2013; RCPCH. 2017d
LoE 2++


**Recommendation level
A***

Fractures

No. 88 Evidence-based Recommendation **Strong consensus (97%)**

In children and adolescents with fractures, their age and developmental stage should* be taken into account when assessing a suspicion of abuse.

Source: Kemp et al. 2006; Kemp et al. 2008; RCPCH. 2017d
LoE 2++


Recommendation level B*

No. 89 KKP with plausibility validation **Strong consensus (100%)**

In children with **multiple fractures** and lack of witnessed accidental injury or doubtful anamnesis, the suspicion of abuse must* be investigated through structured clarification. This includes checking the indication for a standardised skeletal survey and course of action according to OPS 1-945.

Source: Kemp et al. 2008; RCPCH. 2017d
LoE 2++

Recommendation level A*

No. 90 KKP with plausibility validation **Strong consensus (97%)**

In **children < 48 months of age** with a **skull fracture without intracranial injuries** and lack of witnessed accidental injury or doubtful anamnesis, the suspicion of abuse should* be investigated through structured clarification, including documentation of the number of fractures and fracture type. This includes checking the indication for a standardised skeletal survey, a funduscopy and course of action according to OPS 1-945. In the case of **multiple and/or complex skull fractures** the probability of abuse being the cause increases.

Source: Kemp et al. 2008, RCPCH. 2017b; RCPCH. 2017d
LoE 2++

Recommendation level B*

No. 91 Evidence-based Recommendation

Strong consensus (97%)

In children from **19 to 48 months of age** with at least one **rib fracture**, the suspicion of abuse as the cause should* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey, a funduscopy and course of action according to OPS 1-945 should* be performed.

Source: Kemp et al. 2008; Paine et al. 2016; RCPCH. 2017b;
LoE 2++ RCPCH. 2017d

Recommendation level
B*

No. 92 Evidence-based Recommendation

Strong consensus (100%)

In children **< 18 months of age** with at least one **rib fracture**, abuse as the cause must* be ruled out. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey, a funduscopy, a magnetic resonance tomography of the head and course of action according to OPS 1-945 must* be performed.

Source: Paine et al. 2016; RCPCH. 2017b
LoE 2++

Recommendation level
A*

No. 93 KKP with plausibility validation

Strong consensus (100%)

In children **< 18 months of age** with a **humerus fracture** the suspicion of abuse must* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey and course of action according to OPS 1-945 must* be performed.

Source: Kemp et al. 2008; Maguire et al. 2013; RCPCH. 2017d
LoE 2++

Recommendation level
A*

No. 94 KKP with plausibility validation

Strong consensus (100%)

In children **< 18 months of age** with a **forearm fracture** the suspicion of abuse should* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey and course of action according to OPS 1-945 should* be performed.

Source: RCPCH. 2017d
LoE 2++

Recommendation level
B*

No. 95 KKP with plausibility validation

Strong consensus (100%)

In children < 18 months of age with a **femur fracture** the suspicion of abuse must* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey and course of action according to OPS 1-945 must* be performed.

Source: Kemp et al. 2008; Maguire et al. 2013; RCPCH. 2017d;
LoE 2++ Wood et al. 2014

Recommendation level
A*

No. 96 KKP with plausibility validation

Strong consensus (100%)

In children < 18 months of age with a **lower leg fracture** the suspicion of abuse should* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey and course of action according to OPS 1-945 should* be performed.

Source: RCPCH. 2017d
LoE 2++

Recommendation level
B*

No. 97 KKP with plausibility validation

Strong consensus (100%)

In children < 18 months of age with a **metaphyseal fracture** of the long bones, the suspicion of abuse must* be investigated. If there is a non accidental injury or a doubtful anamnesis, a standardised skeletal survey, funduscopy, magnetic resonance tomography of the skull and course of action according to OPS 1-945 should* be performed.

Source: Kemp et al. 2008; RCPCH. 2017d
LoE 2++

Recommendation level
A*

No. 98 KKP with plausibility validation

Strong consensus (100%)

If there is a non accidental injury or a doubtful anamnesis in children with a **spinal injury**, the suspicion of abuse must* be investigated.

The indication for a standardised skeletal survey must* be checked and course of action followed according to OPS 1-945. In the event of suspected abuse, in addition to magnetic resonance tomography of the spine a magnetic resonance tomography of the skull must* also be performed.

Source: Kemp et al. 2010
LoE 2++

Recommendation level
A*

No. 99 KKP with plausibility validation

Strong consensus (97%)

If there is a non accidental injury or a doubtful anamnesis in children with a **pelvis injury**, the suspicion of physical and sexual abuse must* be investigated as the cause. The indication for a standardised skeletal survey should* be checked here and course of action according to OPS 1-945 must* be followed.

Source: RCPCH. 2017d
LoE 2++

Recommendation level
A*

Non accidental visceral injuries

No. 100 Evidence-based Recommendation

Strong consensus (100%)

In children < 48 months of age with visceral injuries, such as duodenal, liver, spleen, pancreas and/or intrathoracic injuries, the suspicion of abuse must* be investigated if there is a lack of accidental injuries; this also applies if there are no haematomas on the abdomen.

Source: Maguire et al. 2013
LoE 2++

Recommendation level
A*

4.4.5 Eye examination

Fig. 15 Examination, documentation and odds ratio in the case of suspected retinal haemorrhage

Eye examination	
Indication	Children < 24 months of age with suspected NAHI
Examination	<ul style="list-style-type: none"> ▪ Ophthalmological examination ▪ Both sides ▪ Indirect funduscopy through the dilated pupils
Explicit written documentation	<ul style="list-style-type: none"> ▪ Is a retinal haemorrhage present? ▪ Is the haemorrhage one-sided or two-sided? ▪ What is the manifestation of the retinal haemorrhage? (mild (1-10 haemorrhages), moderate (11-20 haemorrhages) or severe (>20 haemorrhages)) ▪ Are multiple layers of the retina affected? ▪ Are multiple sections of the eye affected? ▪ Where are the haemorrhages located within the fundus? (parapapillary, posterior pole, periphery, etc.) <p>(documentation possible with the 'RetCam')</p>
Findings that increase the probability of NAHI	<ul style="list-style-type: none"> ▪ Increase of number of retinal haemorrhages ▪ Spreading of retinal haemorrhages peripherally
Retinal haemorrhages in the case of NAHI	OR 15.31 (95% CI 18.78-25.74)

AIMS

- ▶ Objectify maltreatment indicators
- ▶ Establish (developmental) prognosis
- ▶ Communicate assessment securely

Eye examinations

No. 80 Evidence-based Recommendation		Strong consensus (100%)
In children < 24 months of age with a head injury suspected of being caused by abuse, a thorough ophthalmological examination (dilated pupils and indirect funduscopy) must* be performed.		
Source: LoE 2++	Maguire et al. 2013; RCPCH. 2017c	Recommendation level A*

No. 101 Evidence-based Recommendation	Strong consensus (100%)
<p>The examination of the eyes must* be performed on both sides, indirectly through the dilated pupil and in a standardised manner by an ophthalmologist.</p>	
<p>The following questions must* be answered:</p>	
<ul style="list-style-type: none"> ▪ Is a retinal haemorrhage present? ▪ Is the haemorrhage one-sided or two-sided? ▪ What is the manifestation of the retinal haemorrhage? (mild (1-10 haemorrhages), moderate (11-20 haemorrhages) or severe (>20 haemorrhages)) ▪ Are multiple layers of the retina affected? ▪ Are multiple sections of the eye affected? ▪ Where are the haemorrhages located within the fundus? (parapapillary, posterior pole, periphery, etc.) 	
<p>With the increase of the number of findings and/or spreading to the periphery, the probability of head injury caused by abuse increases.</p>	
<p>Source: Bhardwaj et al. 2010; Morad et al. 2003; RCPCH. 2017c LoE 2++ to 3</p>	<p>Recommendation level A*</p>

No. 102 Evidence-based Recommendation	Strong consensus (100%)
<p>In the case of a suspected head injury caused by abuse, examination of the eyes should* take place promptly, if possible within the first 24 hours after the child has been presented.</p>	
<p>KKP: Here it should* be noted that the time of a possible incident does not correspond with the time when the child was first presented, for instance, to a hospital. As the time increases from when the incident occurred (up to four weeks), the likelihood of verifying previous retinal bleeding diminishes.</p>	
<p>Source: Binnenbaum et al. 2016; Watts et al. 2013 LoE 2++ bis 2+</p>	<p>Recommendation level B*</p>

No. 103 Evidence-based Recommendation	Strong consensus (100%)
<p>In children with the following singular occurrences, the probability of retinal bleeding is very low to not present:</p>	
<ul style="list-style-type: none"> ▪ Cerebral seizures ▪ "Apparent Life-Threatening Events" (ALTE), now "Brief Resolved Unexplained Events" (BRUE) ▪ Strained coughing ▪ Strained vomiting ▪ Cardiopulmonary reanimation. 	
<p>If these children have retinal bleeding, the suspicion of abuse as the cause should* be investigated.</p>	
<p>Source: RCPCH. 2017c LoE 2++</p>	<p>Recommendation level B*</p>

4.4.6 Differential diagnoses

No. 104 Evidence-based Recommendation **Consensus (88%)**

In children and adolescents with confirmed diagnosis of abuse, no further diagnostics should* be performed to exclude illnesses that could imitate the abuse of a child.

Source: Pereira et al. 2015; Scholl-Burgi et al. 2016; Vester et al. 2015; Zarate et al. 2016 **Recommendation level B***

LoE 2- to 4

No. 105 Evidence-based Recommendation **Strong consensus (100%)**

In children and adolescents with a suspicion of abuse, other causes (e.g. accidents or illnesses that could imitate abuse) should* be included in the differential diagnostics.

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014; Pereira et al. 2015; Scholl-Burgi et al. 2016 **Recommendation level B***

LoE 2+ to 4

No. 106 Evidence-based Recommendation **Strong consensus (100%)**

The following illnesses should* be taken into account in terms of differential diagnostics in children and adolescents with fractures suspected of being caused by abuse without a confirmed diagnosis of abuse:

1. Osteochondrodysplasia (e.g. Osteogenesis imperfecta, osteopetrosis, pycnodysostosis)
2. Rickets
3. Menkes disease
4. Liver and kidney failure (chronic)
5. Familial hypocalciuric hypercalcemia (FHH)
6. Pain insensitivity syndrome (for example: hereditary sensory and autonomic neuropathies (HSANs))
7. Hyper IgE-syndrome.

The estimated cumulative prevalence of the illnesses listed is 1 out of 50,000-100,000 children and adolescents under 18 years of age in Germany.

The differential diagnostic consideration should* be performed according to the following criteria:

- Personal and family anamnesis
- Physical and neurological examination
- Skeletal survey (to determine bone metabolism and search for signs of a syndrome)
 - Standard for children < 24 months of age (see No. 83 & 85)
 - Children and adolescents > 24 months of age require the case-to-case decision of at least two doctors.

If the performed examinations are normal, the presence of these illnesses is virtually ruled out.

If one of the performed examinations is abnormal or child abuse is still suspected, further examinations should* be performed (see No. 107).

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014 **Recommendation level B***

LoE 2+ to 3

No. 107 Evidence-based Recommendation

Strong consensus (100%)

The following examinations should* be performed as part of differential diagnostics (see No. 106) in children and adolescents suspected of being abused without a confirmed diagnosis of abuse:

- in blood: small haemogram
- in serum: calcium, phosphate, alkaline phosphatase, 25 OHD, PTH, copper, ceruloplasmin, transaminases, bilirubin, bile acids, creatinine, IgE
- in urine: calcium, phosphate, creatinine

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014
LoE 2+ to 3

Recommendation level B*

No. 108 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with fractures suspected of being caused by abuse and no confirmed diagnosis of abuse, the corresponding medical disciplines should* be consulted in the event of abnormalities or positive findings from Recommendations for Action No. 106 or No. 110.

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014
LoE 2+ to 3

Recommendation level B*

No. 109 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with fractures suspected of being caused by abuse and no confirmed diagnosis of abuse, the corresponding specialised discipline should* be consulted in the event of abnormalities or positive findings from recommendation No. 110.

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014
LoE 2+ to 3

Recommendation level B*

No. 110 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with an intracranial head injury suspected of being caused by abuse, the following illnesses should* be considered for differential diagnosis:

1. Glutaric acidemia Type I
2. Methylmalonic acidemia and homocystinuria Type cBIC
3. D-2-hydroxyglutaric aciduria
4. Progressive familial intrahepatic cholestasis Type II
5. Menkes disease
6. Osteogenesis imperfecta
7. Infantile osteopetrosis
8. Cerebral arterial aneurysm
9. Cerebral arteriovenous malformations
10. Blood clotting disorders
11. Liver failure.

The estimated cumulative prevalence of the illnesses listed is 1 out of 1000 children and adolescents under 18 years of age in Germany.

The differential diagnostic consideration of these illnesses should be performed according to the following criteria:

- Personal and family anamnesis, especially bleeding and clotting anamnesis (see No. 67)
- Physical and neurological examination
- Examination of ocular fundus (see No. 101)
- Laboratory examinations as Recommendation No. 107, and in addition
 - in serum: homocystein, coagulation analysis (global test, factor analysis, platelet function test) - if possible, in consultation with a (paediatric) haemostaseologist
 - in urine: organic acids
- cMRT
- Skeletal survey (to determine bone metabolism and search for signs of a syndrome)
 - Standard for children < 24 months of age (see No. 83 & No. 85)

Children and adolescents > 24 months of age require the case-to-case decision of at least two doctors.

Source: AWMF-S3 Child Protection Guideline Office 2018; Metz et al. 2014

Recommendation level B*

No. 111 KKP with plausibility validation

Strong consensus (100%)

In children and adolescents with skin injuries suspected of being caused by abuse, and no confirmed diagnosis of abuse, specialised disciplines (e.g. dermatology, forensic medicine, doctors with child protection experience) should* be consulted promptly.

Source: Metz et al. 2014

Recommendation level B*

4.4.7 Diagnostics in the case of suspected sexual abuse

Fig. 16 (chronological) sequence of possible examinations in the case of suspected sexual abuse

Examinations of children and adolescents where sexual abuse is suspected.			
Has there been an occurrence with or without sexual assault*?			
Examination	Time since (last) sexual assault		
	<24 hours	24 hours to 7 days	>7 days
Full body examination	Must	Must	Must
Comprehensive anamnesis	Must	Must	Must
Structured anamnesis**	Must	Should	Should
Anogenital and/or paediatric gynaecological examination with the aid of video colposcope	Must	Should	Can
Examination for sexually transmitted diseases	Must	Should	Should
Pregnancy test (girls in childbearing age)	Must	Should	Should
Search for traces (DNA, semen, sperm)	Must	Should	Should (refers only to clothing, bed sheets, etc.)
Forensic interview (4 – 18 years)	>24 hrs.	Should	Should
Assessment of the psychological state	>24 hrs.	Should	Should

▼

For every individual case: Assessment by a multi-disciplinary team	
<ul style="list-style-type: none"> ▪ Anogenital and/or paediatric gynaecological examination with the aid of video colposcope ▪ Examination for sexually transmitted diseases ▪ Pregnancy test (girls in childbearing age) ▪ Search for traces (DNA, semen, sperm) ▪ Forensic interview/structured questioning (4 – 18 years) ▪ Assessment of the psychological state 	<p>What incident has occurred?</p> <ul style="list-style-type: none"> ▪ Check necessity & relevance ▪ Determine point in time & sequence

▼

Attention: Consent!
No examination is performed against the will of the children or adolescents.
The consent of minors capable of giving consent or of the primary caregiver must be provided.***

▼

Analysis of all findings
Is it possible to confirm or invalidate the suspected case?
Determine further course of action.

*Criteria for a sexual assault

- Contact with the genitals, semen, blood or saliva of the perpetrator
- struggle that took place, that could have left the skin or blood of the suspected perpetrator on the victim's body
- possible contamination on clothing or body of the victim

**e.g. P-SANE (see Annex 2)

***Note "[Medical treatment of minors after sexual violence without involving the parents](#)" (2018)

No. 112 Evidence-based Recommendation

Strong consensus (97%)

All children and adolescents suspected of having been sexually abused must* be examined in a manner specific to their gender and level of development.

An examination must not* be performed against the will of the child/adolescent.

The necessity and setting the date for the above examinations depend on the period of time between the indicated sexual assault and the time of the examination (see No. 115 to No. 118 and Fig. 8).

In addition to the full body examination and comprehensive anamnesis, a(n)

- anogenital and/or paediatric gynaecological examination with the aid of video colposcope (see No. 114)
- examination for sexually transmitted diseases (see No. 119)
- pregnancy test (girls in childbearing age)
- search for trace evidence (DNA, semen, sperm)
- forensic interview (4 – 18 years)
- assessment of the psychological state

must* be performed.

The necessity and sequence of individual examinations must* be determined for each individual case by a multi-professional team (e.g. child protection group).

The findings of all examinations must* be evaluated jointly and in context.

Source: Adams et al. 2015; Adams et al. 2018; Campbell et al. 2009; Crawford-Jakubiak et al. 2015; Girardet et al. 2011; Killough et al. 2015

LoE 2+ to 3



Recommendation level A*

No. 113 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents with a serious acute injury and suspected of having been sexually abused and sexually assaulted, injury to the abdominal region and pelvis should* be ruled out immediately.

Source: Abraham et al. 2016; RCPCH. 2017d

LoE 2++ to 3

Recommendation level B*

No. 114 Evidence-based Recommendation

Strong consensus (100%)

In **girls** suspected of having been sexually abused, the anal and paediatric gynaecological examination should* be performed in four positions depending on age and level of development:

1. Frog leg or lithotomy position
2. Knee-chest position
3. Lateral position
4. Supine with knees towards chest.

In **boys** suspected of having been sexually abused, the anogenital examination should* be performed in three positions depending on age and level of development:

1. Knee-chest position
2. Lateral position
3. Supine with knees towards chest.

Source: Adams et al. 2015; Myhre et al. 2013
LoE 2+

Recommendation level
B*

No. 115 Evidence-based Recommendation

Strong consensus (100%)

In children and adolescents suspected of having been sexually abused, the anogenital and/or paediatric gynaecological examination should* be performed by a medical specialist with child protection experience and special expertise in paediatric-forensic diagnostics. The examination should* be documented by photos, or ideally by video and assessed according to the Adams criteria, in order to provide them for peer reviewing if necessary.

The consent of the children and adolescents is required for the examination (see No. 112).

For better comprehension, the categorisation in accordance with Adams can be simplified as follows:

Findings categories	Assessment
<ol style="list-style-type: none"> 1. Normal findings 2. Normal variations 3. Differential diagnoses that are mistaken for abuse 	normal
<ol style="list-style-type: none"> 1. Findings from injury and/or sexual contact <ol style="list-style-type: none"> a. Acute injuries of the genitals and/or anus, that could be accidental or inflicted. b. Residual (healing) injuries of the genitals and/or the anus 2. Findings that point to an acute or healing injury of the genitals and/or anus 	abnormal

Source: Adams et al. 2018

Reference
Guideline

Recommendation level
B*

No. 116 Evidence-based Recommendation		Strong consensus (100%)
<p>In children and adolescents suspected of having been sexually abused, the anogenital and/or paediatric gynaecological examination must* be performed immediately (within the first 24 hours) after the (last) sexual assault.</p> <p>During this period a structured anamnesis (e.g. P-SANE, see Annex 2), the examination for sexually transmitted diseases, securing of evidence, and a pregnancy test (see No. 123) must* be performed.</p>		
Source:	Adams et al. 2015; Campbell et al. 2009; Hornor et al. 2012; McCann et al. 2007; Palusci et al. 2006; Watkeys et al. 2008	Recommendation level A*
LoE 2+ to 3		

No. 117 Evidence-based Recommendation		Strong consensus (97%)
<p>In children and adolescents suspected of having been sexually abused who have not yet been examined (within the first 24 hours; see No. 116), an anogenital and/or paediatric gynaecological examination should* be performed as close as possible (within the first 72 hours until maximum 7 days) to the (last) sexual assault.</p> <p>As part of this visit, the structured anamnesis (e.g. P-SANE, see Annex 2), examination for sexually transmitted diseases, securing of evidence (foreign DNA), a pregnancy test (see No. 123) and the forensic interview (4-18 years of age) should* be performed (see Fig. 8).</p>		
Source:	Adams et al. 2015; Hornor et al. 2012; Watkeys et al. 2008	Recommendation level B*
LoE 2+ to 3		

No. 118 Evidence-based Recommendation		Strong consensus (97%)
<p>In children and adolescents suspected of having been sexually abused who have not yet been examined (see No. 116 & No. 117) and for whom the (last) sexual assault occurred more than a week prior, an anogenital and/or paediatric gynaecological examination should* be offered (see also No. 112).</p>		
Source:	Hobbs et al. 2014	Recommendation level B*
LoE 2+ to 3		

No. 119 Evidence-based Recommendation		Consensus (90%)
<p>In children and adolescents suspected of having been sexually abused who have not yet been examined (see No. 116 to 118), the structured anamnesis (e.g. SANE-P, see Annex 2), examination for sexually transmitted diseases, pregnancy test (see No. 123), should* be performed even after a week to several weeks from the (last) sexual assault, and a forensic interview (4-18 years of age) should be offered.</p>		
Source:	Hornor et al. 2012	Recommendation level B*
LoE 3		

No. 120 Evidence-based Recommendation

Strong consensus (100%)

After the sexual assault of children and adolescents, the following must* be examined for the following sexually transmitted diseases:

- Urine test for:
 1. *Chlamydia trachomatis*
 2. *Neisseria gonorrhoea*
 3. *Trichomonas vaginalis*
- } Nucleic acid amplification testing (NAAT/PCR) in urine
- Anal pap smear for:
 1. *Chlamydia trachomatis*
 2. *Neisseria gonorrhoea*
- } Nucleic acid amplification testing (NAAT/PCR)

In the case of children and adolescents with discharge, the sexually transmitted diseases listed above (1-3) must* be additionally examined in a swab of the exudate by means of NAAT/PCR.

Follow-up tests must* be performed according to the applicable infectiological recommendations. Also, testing of the indication to perform a post-exposure prophylaxis (for instance, in the case of suspicion of HIV) must* be performed in accordance with the applicable infectiological recommendations.

Every positive laboratory result must* be confirmed by the respective pathogen-specific test (confirmation test).

Source: Andersen et al. 2013; Adams et al. 2015; Adams et al. 2018; Esernio-Jenssen et al. 2011; Girardet et al. 2009; Joki-Erkkila et al. 2016; Ramos et al. 2006; Reading et al. 2007; Reading et al. 2014; Unger et al. 2011

Recommendation level
A*

No. 121 Evidence-based Recommendation

Strong consensus (100%)

The following measures should* be performed for children and adolescents with condylomata accuminata:

1. Personal and third party anamnesis for skin and genital warts
2. HPV-vaccine anamnesis
3. Sexual and abuse anamnesis
4. Examinations, including anogenital and/or paediatric gynaecological examination

HPV and/or condylomata accuminata can be transferred through both sexual contact as well as non-sexual contact. The results of the recommended measures (1-3) should* be assessed by specialists (e.g. medical specialists with child protection experience, virologists or infectiologists) and evaluated in the overall diagnostic context.

Source: Adams et al. 2018

Reference
Guideline

Recommendation level
B*

No. 122 Evidence-based Recommendation		Strong consensus (100%)
<p>In children and adolescents with a confirmation of a sexually transmitted disease with unclear origin, suspicion of sexual abuse (including trafficking and exploitation of children) must* be investigated (see No. 112 to No. 120).</p>		
Source:	Adams et al. 2015/2018; Crawford-Jakubiak et al. 2015;	Recommendation level
LoE 1+	Brayley-Morris et al. 2015	

No. 123 Evidence-based Recommendation		Strong consensus (97%)
<p>In girls of childbearing age suspected of having been sexually assaulted and abused, a pregnancy should* be ruled out with regard to the further procedure (e.g. "morning-after pill"). The (first) pregnancy test (β-HCG in urine or serum) should* be performed during the first contact.</p>		
Source:	Adams et al. 2018; Crawford-Jakubiak et al. 2015; Hornor	Recommendation level
LoE 3	et al. 2012	

No. 124 Evidence-based Recommendation		Consensus (93%)
<p>In children and adolescents suspected of having been sexually abused, the securing of evidence must* take place depending on the time that has lapsed from the (last) sexual assault:</p> <p>with regard to the body of the child/adolescent (see No. 116 to 116):</p> <ul style="list-style-type: none"> ▪ Foreign DNA: Nucleic acid amplification testing (NAAT/PCR) in a smear ▪ Semen: Microscopy of the prepared smear ▪ Sperm: e.g. acid phosphatase <p>with regard to the clothing of the child/adolescent, bed sheets, etc.:</p> <ul style="list-style-type: none"> ▪ Foreign DNA <p>Potentially wetted items of clothing (even clothing that has been washed several times) must* be dried and stored in paper in a legally secure manner. A successful examination is still possible weeks to months after a sexual assault. The chain of evidence must* be preserved.</p> <p>The laboratory examinations must* be performed in a forensic-accredited laboratory.</p>		
Source:	Brayley-Morris et al. 2015; Thackeray et al. 2011	Recommendation level
LoE 1+ to 2+		

<p>No. 125 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>In children and adolescents suspected of having been sexually abused and with acute intoxication, a toxicological examination of the (first) urine and serum should* be performed at the same time as evidence is secured. The examination of a retention sample is performed in a forensic-accredited laboratory.</p>	
<p>Source: Crawford-Jakubiak et al. 2015</p>	
<p>Reference Guideline</p>	<p>Recommendation level B*</p>

<p>No. 126 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>In children and adolescents suspected of having been sexually abused, an exploration specific to the gender and development level of their psychological state should* be performed as well as diagnostics to determine possible traumatisation and the degree of traumatisation.</p>	
<p>Source: Crawford-Jakubiak et al. 2017</p>	
<p>Reference Guideline</p>	<p>Recommendation level B*</p>

<p>No. 127 Evidence-based Recommendation</p>	<p>Strong consensus (100%)</p>
<p>In children and adolescents suspected of having been sexually abused and/or neglected, sexualised behaviour should* be expertly assessed in accordance with the age, gender and development level. Evidence for the assessment of sexualised behaviour is present in children from two to six years of age (examples are described in the Reference Guideline from Kellogg et al. 2009).</p>	
<p>Source: Kellogg et al. 2009</p>	
<p>Reference Guideline</p>	<p>Recommendation level B*</p>

4.5 Child Siblings

No. 128 KKP with plausibility validation		Strong consensus (96%)
<p>The suspicion of child abuse and/or neglect should be investigated in the case of contact children, if child abuse and/or neglect is established in an index patient. The assessment should* be conducted by a multi-disciplinary team (e.g. child protection group).</p>		
Source:	Ellaway et al. 2004; Hamilton-Giachritsis et al. 2005; Lang et al. 2013; Lindberg et al. 2012; Lindberg et al. 2013	Recommendation level B*
LoE 2++ bis 2+		

No. 129 Evidence-based Recommendation		Strong consensus (100%)
<p>In index patients with serious abuse¹, the contact children should* among other things be physically examined and radiological diagnostics should be performed according to clinical indicators.</p> <p>If these contact children are < 24 months of age, a skeletal survey should* be performed (see No. 83 & No. 85 and Fig. 6).</p> <p>¹Serious physical injuries like fractures, burns, head or visceral injuries or treatment in intensive care unit or death as a result of abuse.</p>		
Source:	Lindberg et al. 2012	Recommendation level B*
LoE 2++		

No. 130 Evidence-based Recommendation		Strong consensus (100%)
<p>To assess the possible abuse of children < 12 months of age, among other things the comprehensive anamnesis of the siblings should* be consulted.</p>		
Source:	Ellaway et al. 2004	Recommendation level B*
LoE 2+		

4.6 Interventions for parents*

<p>No. 131 Evidence-based Recommendation</p> <p>Abusive and/or neglectful primary caregivers and attachment figures must* be offered measures to protect the children and adolescents from re-victimisation. Reliable evidence is available for individual measures, such as Parent-Child Interaction Therapy.</p> <p>Source: Barlow et al. 2006; Chaffin et al. 2011</p> <p>LoE 1++ bis 1+</p>	<p>Strong consensus (100%)</p> <p>Recommendation level A*</p>
<p>No. 132 Evidence-based Recommendation</p> <p>Measures for primary caregivers/attachment figures to protect the children and adolescents from re-victimisation must* be characterised by a theoretical approach that deals with the problems in question regarding the abusive and/or neglectful behaviour of the primary caregivers/attachment figures (e.g. strengthening the motivation of the primary caregivers/attachment figures, followed by parent-child interaction).</p> <p>Source: Barlow et al. 2006; Berg & Jones 1999; Chaffin et al. 2011</p> <p>LoE 1++ to 3</p>	<p>Consensus (94%)</p> <p>Recommendation level A*</p>
<p>No. 133 Evidence-based Recommendation</p> <p>The therapy, treatment or involvement of the abusive and/or neglectful primary caregiver/attachment figure must* be adapted appropriately to the form of child abuse and/or neglect that has occurred. Theoretical approaches for measures should refer to the misconduct of this person¹, for instance destructive parenting, attributing fault, dysfunctional bonding and interaction between this person¹ and the child, and also include training this person's¹ parenting skills.</p> <p>¹ neglectful or abusive primary caregiver and attachment figures.</p> <p>Source: Barlow et al. 2006; Chaffin et al. 2011; Chaffin et al. 2012; Moss et al. 2011; Mullins et al. 2005; Runyon et al. 2010; Stronach et al. 2013</p> <p>LoE 1++ to 3</p>	<p>Strong consensus (97%)</p> <p>Recommendation level A*</p>

No. 134 Evidence-based Recommendation

Consensus (87%)

When providing intervention measures for abusive and/or neglectful primary caregivers/attachment figures to protect the children and adolescents from revictimisation, children and adolescents should* be involved to the degree to which they agree to.

Source: Moss et al. 2013; Runyon et al. 2010

LoE 1+ to 1-

Recommendation level

B*

Dissenting opinion "Interventions for parents"

The recommendations for interventions for parents and attachment figures who have provoked a threat to child welfare, are not sufficient due to the selected search strategy method, in terms of the assertions regarding possible assistance and support options. Interventions could be more versatile than what the result of a literature search can portray. They must be viewed in relation to the child in an age-specific manner, in relation to the parents also depending on possible personal psychological illnesses etc. Furthermore, it depends on the type of threat to child welfare (e.g. these can be very different depending on if there is a case of neglect or suspicion of abuse). Furthermore, the structure of early assistance and the entire differentiated area of parenting assistance within the framework of SGB VIII has not been sufficiently considered in this recommendation at this point. Programmes like STEEP or developmental-psychological counselling etc. are not mentioned. Thus, it is necessary to reach beyond the cited study situation actions as part of interventions of parents and attachment figures who may have provoked a threat to child welfare in Germany, to youth welfare service, the healthcare sector and other existing structures.

The DGKJP and the BAGkjpp consider these recommendations for a guideline with validity in Germany to be insufficient, to the extent that further measures are advisable in this area.

**German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy
&
the National Association of Leading Clinicians
for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy**

The portrayals of the recommendations for action with regard to interventions for primary caregivers and attachment figures are too undifferentiated, and do not sufficiently take into account the support options of the SGB VIII youth welfare services.

Federal Conference for Educational Counselling e.V.

5 Outlook

5.1 Validity and update

Due to currently unavailable financial resources, an updating procedure is not possible at this time. An update of the Guidelines after five years have passed - measured from the time of publication in written form - is envisaged by the leading expert associations.

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Appendices

Appendix 1 Transforming cases to PICO



Transforming cases to PICO: Methodology of the evidence-based child protection guideline

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Background

Many providers, outside of traditional health care professionals, such as doctors, nurses and midwives, play a significant role in promoting and providing services to ensure the health and wellbeing of individuals and the community. A network of communication, collaboration and cooperation between these service providers is required to achieve healthcare goals for the population. The inclusion of these non-healthcare/medical actors in the development of clinical practices can not only enhance the understanding of the topic but potentially provide insight into important areas to cover in clinical practice guidelines, including child protection. The wellbeing and safety of children is paramount; to support and facilitate the protection of children certain providers, such as social services, need to be engaged to find alternative care arrangements. Currently there is no national evidence based clinical practice guideline (German AWMF S3) for child protection. Furthermore other current international child protection guidelines have not used case-based, practice-related approach to the guideline development.



Figure 1. Numerous partners from different service providers are involved in the child protection circle, which centres around the health, wellbeing and needs of the child or adolescent.

Representatives from 80 different professional societies, organisations and government ministries representing medicine and healthcare, youth and social services, education and other partners from the child protection circle were involved in the guideline development.

Aim

- To develop PICO & determine the relevant topics in the clinical practice guideline using a case based, practice orientated approach, involving professionals from healthcare/medical, education and social services
- To compose an overarching child centred, practice relevant, clinical practice guideline. The guideline covers 5 forms of child maltreatment and focuses on child maltreatment prevention, detection, diagnosis and protection measures. Cooperation between healthcare and social service professionals is an important consideration in the guideline

Method

- Survey developed by guideline office in conjunction with the steering committee
- The survey was conducted to gain a representative overview of child protection cases and the uncertainties in dealing with child protection cases in every day professional life in Germany
 - Collaboration and communication between these different professional agencies was of particular focus
 - 55 questions relevant to each case covering
 - personal demographic information - profession, years of experience etc.
 - information about the child, parents & siblings
 - detailed description of the case
 - further actions or interventions
 - ranking of relevance & importance of the case in the development of the clinical practice guidelines
 - personal reflection – gaps in knowledge
- Participants: Members of the 80 professional societies and organisations involved in the development of the guideline
- Analysis: Descriptive analysis of data

Results

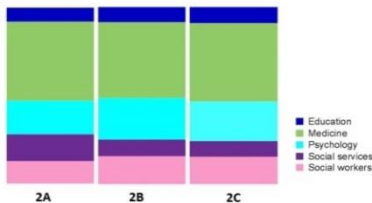


Figure 2. The distribution of the (A) professional societies and organisations (n = 80) involved in guideline development (B) the survey participants (n = 258) and (C) cases reported (n = 476) in the survey according to the different service provider groups.

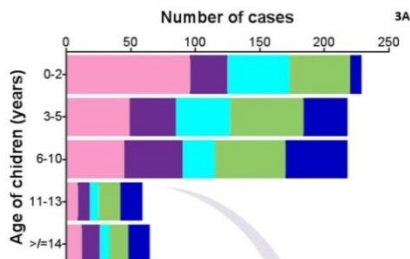
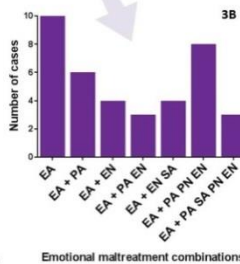


Figure 3A. Shows the distribution of the cases (n = 476) reported in the online survey according to the age of the children and form of maltreatment.

Figure 3B. Shows some of the different combinations maltreatment reported in the survey according to emotional maltreatment for children aged between 6 and 10 years of age. 38 of the 45 cases are represented.



EA = emotional abuse; PA = Physical abuse; SA = sexual abuse; EN = emotional neglect; PN = physical neglect

Take home message

- Reported cases from a variety of traditional and non-traditional healthcare providers can provide an overall insight into a healthcare problem and serve as a basis for a practice relevant and related guideline
- To maximise the outcomes and relevance, this approach requires cooperation from representatives from all service providers throughout the entire guideline development process

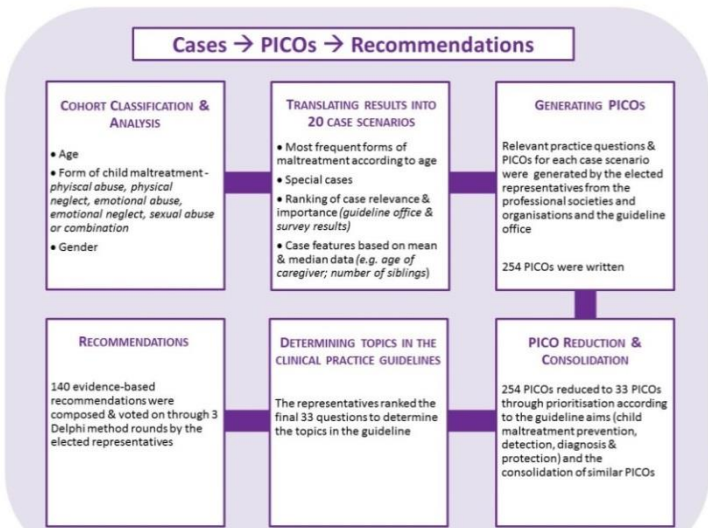


Figure 4. The approach used to convert the results of the online survey, where 476 real cases were reported, into case scenarios that served as the basis for the PICO and final topics covered in the AWMF S3+ CHILD (SEXUAL) ABUSE AND NEGLECT GUIDELINE-INCLUDING YOUTH WELFARE AND EDUCATION.

Appendix 2 Paediatric Sexual Assault Nurse Examiner (P-SANE) Questionnaire from Hornor et al. 2012

Table 1 Evidence Collection Worksheet P-SANE	
Patient	Name: _____
Medical	Record # _____
Law	enforcement officer: _____
Law	enforcement jurisdiction: _____
Date	and time of sexual assault/abuse: _____
Date and time of exam: _____	
Patient gives history of: <input type="checkbox"/> Genital-Genital Contact <input type="checkbox"/> Anal-Genital Contact <input type="checkbox"/> Digital-Genital Contact <input type="checkbox"/> Digital-Anal Contact <input type="checkbox"/> Fondling of Breasts <input type="checkbox"/> Fondling of Genitalia <input type="checkbox"/> Oral-Genital Contact <input type="checkbox"/> Oral-Genital Contact (Perpetrator to Victim) (Victim to Perpetrator) <input type="checkbox"/> Masturbation <input type="checkbox"/> Other Sexual Deviant Behavior Ejaculation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Condom used: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Lubrication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Since the assault/abuse patient has: Douched: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Defecated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Urinated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Vomited: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Changed clothes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Bathed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Had food/drink <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Brushed teeth <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know At the time of the assault was: Patient menstruating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Tampon present <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	Consensual sexual activity within 72 hours: <input type="checkbox"/> Yes <input type="checkbox"/> No Positive DNA found: Clothing: <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other (Item: _____) Oral swab: <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Anal swab: <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Vaginal/urethral <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Cervical <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Dried Stains <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other (Location: _____) Fingernails <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Pubic hair <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Other Ano-Genital exam: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Describe finding _____) Positive STD results: GC culture <input type="checkbox"/> oral <input type="checkbox"/> anal <input type="checkbox"/> vaginal/urethral <input type="checkbox"/> cervical Chlamydia culture <input type="checkbox"/> anal <input type="checkbox"/> vaginal/urethral <input type="checkbox"/> cervical Urine DNA amp <input type="checkbox"/> GC <input type="checkbox"/> Chlamydia HIV _____ RPR _____ Hep B surface antigen _____ Urine HCG _____

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