PEER REVIEW HISTORY

BMJ Paediatrics Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	An audit of child maltreatment medical assessments in a culturally diverse, metropolitan setting
AUTHORS	Raman, Shanti; Hotton, Paul

VERSION 1 - REVIEW

REVIEWER	Roylance, Richard School of Medicine Griffith University Australia Competing interests: Nil
REVIEW RETURNED	21-Jul-2017

GENERAL COMMENTS	A useful presentation of the improvement cycle in a non-metropolitan health service. Some aspects are local-centric - buy there are general concepts and broad indices of service delivery that are of interest nationally and internationally. The Project was largely an audit of service enhancements to a clinical service, to assess performance against predetermined outcomes, with a further goal to determine if assessments were conducted in a 'child-friendly' manner. Comments 1) There is an inconsistency, in that the Paper's Title uses the term: "child protection". but throughout the paper the term: "child maltreatment" is used. I would be interested in the authors comments, but my initial thoughts are to suggest that the authors be consistent, use the words child maltreatment in the title, and add child protection to the keywords. 2) There are several references (pg 4,9)in the paper to 'strong focus on children's rights' which are presented as stand-alone statements. The point would benefit from the provision of more context and explanation. As a reader, I am left uncertain as to what are the important constituents of a "child-centred or children's rights promoting child protection medical assessment". Similarly, the paragraph in discussion (pg 9) would benefit from expansion. 3) Is the SWS LHD "the largest, most populous region in Australia"? Geographically largest? Most culturally diverse? Largest population density? 4) In the context - including the number / percentage of identified Aboriginal and Pacific Islander children examined by the service is relevant. 5) Table 1: Suggest a line above the Total Health Concerns row to improve readability. 6) The authors note in the Results section (pg 7) that a number of

	children placed in OOHC and/or having on-going statutory child protection agency involvement had an unknown follow-up, or failed to attend follow-up. This would seem to be an ameliorable issue, and a further measure of holistic care. I suggest that this issue (and possible remediations) receive comment in the Discussion section. 7) There were some minor grammatical errors.

REVIEWER	Sidebotham, Peter Warwick Medical School, UK Competing interests: None
REVIEW RETURNED	03-Aug-2017

GENERAL COMMENTS	This is an important and well-conducted baseline audit of a service for acute medical assessments following suspected child maltreatment. The authors clearly set out relevant standards and evaluated their service against those standards. They have identified aspects of good practice and areas for improvement. As it stands, however, the paper is of limited value to the wider international audience. Without a more full description of the service and some further exploration of the results, it is difficult for others to learn from this in relation to how to improve services. It seems to me that one of the key aspects of the results is the difference between solo forensic examinations and joint forensic/paediatric/social work examinations in identifying and responding to other health needs, and in some aspects of child-friendliness. However, this contrasts with a much shorter mean time to assessment for the solo examinations. Some further exploration of that and of the other outcomes of the assessments between joint and solo examinations is warranted. At its heart there is a question over whether any perceived benefits of a joint over a solo examination outweigh any potential limitations of a longer time to examination, and/or whether either aspects could be improved further. Abstract 'While there is evidence for medical examination in the assessment of CM' Do you mean evidence for the value of medical examination? Or for the existence of medical examination? Or something else? Introduction A good, clear introduction that sets the background and justification for this audit well. The aims are clearly articulated. Much of the first paragraph is unnecessary – you could keep it more focused on the role of the medical assessment rather than a broader history of recognition of child maltreatment. P4, line 6 – Henry Kempe, not Kemp. Methods These are clear. A bit more detail on how the service is structured and how the medical assessments are organised and carried out would be helpful. In particular, it is not clear why some were carried out by SA alone and some jointly. Since this is a crucial aspect of your results, some clarity over this would help. P5, line 40 – Data should be referred to in the plural: 'These data were…' Results P7, line 10 – it would probably be more accurate to state that '204

	cases (73%) were seen for suspected SA' P7, line 13 – you state that 'A detailed description of the demographics, referral and assessment findings of the children have been presented before' and yet the reference given points to a conference abstract with no more detail than is provided here, and with a smaller sample/time frame. It would be helpful to include some further description of the demographics, referral and assessment findings at least as a supplementary appendix. P7, line 30 – it would be helpful to have some indication of what the 'other health concerns' identified were. P7, line 34 – it is unhelpful just to give a Chi-square statistic to state that joint assessments were better than solo SA assessments at identifying health concerns. What were the relative proportions in each group? It would also probably be more accurate to state that joint assessments identified more health concerns or were more likely to identify health concerns than solo SA assessments, rather than that they were better, since you don't have a gold standard to measure against so you are pre-judging that more necessarily means better (which may well be true, but is nevertheless an extrapolation). P7, line 45 –The terminology around 'failed to attend' is unhelpful (also elsewhere throughout the article). 'Was not brought' would be more appropriate. See Appleton JV., Sidebotham P. (2017) Was Not Brought – Take note! Think Child! Take Action! Child Abuse Review. 26(3): 265-171 and the animation at www.youtube.com/watch?v=dAdNL6d4lpk P8, line 13 – 'Table 3 examines measureable aspects of the CM assessments that were deemed child-friendly' – you cannot state that they were child friendly without some way of directly measuring the child's perspective. Table 2 – it would be helpful to make clear that column 2 (SA n=134) refers to solo SA assessments and column 3 to joint SA assessments. I think there could be further clarity over the results presented here. Overall, I calculate that 195/279 (70%) children were offered a follow up medical appointment, and of those, 120 (62%) attended. Among the solo SA assessments, 82/134 (62%) were offered and 45/82 (55%) attended. Similar proportions could be calculated for joint SA and PAN assessments, and for the psychological follow up. It would then be helpful to get some indication of the statistical significance of any differences between the three groups of assessments. It would also be helpful to know whether, for the 19%/39% not offered a follow up medical or psychological assessment did the researchers feel this was appropriate or were there identified health needs that weren't being followed up? Table 3 – a bit more detail is needed along with the mean time to assessment. First, I would suspect the data are non-parametric, so median time might be more appropriate. In addition, it would be helpful to have some indication of range and variance, in particular the proportions seen within particular cut-off points. This is particularly important as you state in the discussion that the majority were seen within the recommended 24-72 hours, but don't provide the actual data for this. Discussion P9, line 15 – you state that the assessments fell short in following children up from a health and wellbeing perspective. This needs a bit more clarity to justify the statement – you can surely only base that on the number with identified health or wellbeing needs who were not offered appropriate follow up.

	P10, line 15 – it would be interesting to explore further (both in the results and the discussion) those children seen out of hours – how many of those were at weekends, or in the middle of the night? There is a general move away from conducting SA assessments at night (particularly for young children) as not being particularly child-friendly and so it would be interesting to reflect on how many of those seen OOH genuinely needed to be seen OOH and how many could perhaps have been seen the following morning. You pick up on this a bit in this paragraph, stating that just under a quarter of SA assessments and 62% of PAN assessments could have been deferred. On what basis did you make those judgements? P10, line 27 – can you speculate/identify reasons why such a high proportion didn't have an accompanying parent/carer? The figure really seems very high and is concerning.

VERSION 1 – AUTHOR RESPONSE

Suggestions	Actions
Reviewer 1	
1) Inconsistency, in that the Paper's Title uses the term: "child protection". but throughout the paper the term: "child maltreatment" is used.	Changed title to **An audit of child maltreatment medical assessments in a culturally diverse, metropolitan setting,** added child protection to key words
2) There are several references (pg 4,9)in the paper to 'strong focus on children's rights' which are presented as stand-alone statements. The point would benefit from the provision of more context and explanation.	Further context and explanation is provided in p4 in the Introduction and p6 in the Methods section, identifying the standards and tools used to explore children's rights in health services. Also clarified in Discussion p8.
3) Is the SWS LHD "the largest, most populous region in Australia"?	Clarified: it is the most populous health district in New South Wales, p4. Also has the largest culturally and linguistically diverse population, p5
4) In the context - including the number / percentage of identified Aboriginal and Pacific Islander children examined by the service is relevant	Number and percentage of Aboriginal and Pacific Islander children provided, p7
5) Table 1: Suggest a line above the Total Health Concerns row	Done
6) The authors note in the Results section (pg 7) that a number of children placed in OOHC and/or having on-going statutory child protection agency involvement had an unknown follow-up, or failed to attend follow-up- ameliorable issue	Further commentary provided in p10 in Discussion about medical and psychosocial follow up of children in OOHC
7) There were some minor grammatical errors.	Edited grammar
Reviewer 2	
1) It seems to me that one of the key aspects of the results is the difference between solo forensic examinations and joint forensic/paediatric/social work examinations in identifying and responding to other health needs, and in some aspects of child-friendliness.	Clarified on p9: Forensic assessments for SA performed as solo examinations had a much shorter mean time to assessment, suggesting that the main focus was on achieving the forensic medical examination in a timely manner. Also further comment in concluding remarks on p11
2) Clarify Abstract wording	Done: While there is evidence for the value of medical examination in the assessment of CM
3) Tighten Introduction	Done
4) Kempe not Kemp	Changed to Kempe
5) A bit more detail on how the service is	Provided in p5 in Methods

structured and how the medical assessments are organised and carried out would be helpful	
6) P5, line 40 – Data should be referred to in the plural	Corrected as: “These data were”, p5
7) P7, line 10	Changed to: 204 cases (73%) were seen for suspected SA
8) P7, line 13 – you state that ‘A detailed description of the demographics, referral and assessment findings of the children have been presented before’	Slightly more details of demographics provided. Another reference added: Hotton P, Raman S. Analysis of acute presentations for child protection medical assessments in a large, culturally diverse metropolitan setting. *BMJ Paediatrics Open* 2017. DOI http://dx.doi.org/10.1136/bmjpo
9) P7, line 30 – it would be helpful to have some indication of what the ‘other health concerns’ identified were	Other health concerns listed on p7
10) P7, line 34 – it is unhelpful just to give a Chi-square statistic to state that joint assessments were better than solo SA assessments at identifying health concerns	Rewritten as suggested: joint assessments (86%) identified more health concerns or were more likely to identify health concerns, than those performed by SA doctors (26%) solely,
11) P7, line 45 –The terminology around ‘failed to attend’ is unhelpful	Replaced with “was not brought” or Were not brought
12) P8, line 13 – ‘Table 3 examines measureable aspects of the CM assessments that were deemed child-friendly’	Agree. Clarified with: using available audit data on timeliness and appropriateness of the assessment, and whether the child was supported by the presence of a parent or parent figure. Also have acknowledged that: Certainly more can and should be done in this space
13) Table 2 – it would be helpful to make clear that column 2 (SA n=134) refers to solo SA assessments and column 3 to joint SA assessments	Done
14) I think there could be further clarity over the results presented here	Agree, further clarification provided on p8
15) Table 3 – a bit more detail is needed along with the mean time to assessment. First, I would suspect the data are non-parametric, so median time might be more appropriate	Changed to Median time along interquartile range.
16) P9, line 15 – you state that the assessments fell short in following children up from a health and wellbeing perspective	Edited to: but fell short in achieving our objectives of adequate and appropriate follow up, both medically and psychologically (p9)
17) P10, line 15 – it would be interesting to explore further (both in the results and the discussion) those children seen out of hours	Already mentioned that: We identified that just under a quarter of SA assessments and 62% of PAN assessments that occurred after hours could have been deferred to the following morning.
18) P10, line 27 – can you speculate/identify reasons why such a high proportion didn’t have an accompanying parent/carer?	We do not have a reason for this but have suggested better inter-agency collaboration between health and welfare services to help support children better

VERSION 2 – REVIEW

REVIEWER	Roylance, Richard School of Medicine Griffith University Australia Competing interests: Nil
REVIEW RETURNED	02-Oct-2017

GENERAL COMMENTS	The article is similar to one recently submitted fro consideration of publication - but of sufficiently different content to present as a separate paper. Overall, there was a degree of redundancy and repetition that would benefit from unreal editorial review. I have made some notes, but as the submission is in PDF rather than word, it is somewhat laborious to provide those to the authors. I would be have to provide revisions to a .docx if that was helpful. In regard to content, i would suggest the following: 1. Pg 6 - A clear (Box? Table? Dot-point list?) of what constitutes a "child friendly" assessment would be helpful to the reader. 2. Table 1: a) Headers: Medical alone, Learning Difficulties alone, Behavioural problems alone b) I suggest: 'Did not attend' rather than 'was not brought'. c) add percentages 3. The last paragraph of the Limitations Section (beginning with 'Nevertheless') is more appropriately placed in the discussion and conclusion section. This issue of the last of followup for children 'in' or 'known' to the statuary authorities who do not attend recommended health follow-up is a significant and 'improvable' component of the system that is being audited. What is the purpose of 'screening' for 'unmet health needs' if the government systems established to support these vulnerable children do not action the recommendations provide by the medical providers. This short-fall is significant (according to the author's results) and is potentially relatively remedial in the content of inter-disciplinary, inter-departmental collaboration - the essential thesis of the 'child rights', child-focused' intervention.

VERSION 2 – AUTHOR RESPONSE

1. Pg 6 - A clear (Box? Table? Dot-point list?) of what constitutes a "child friendly" assessment would be helpful to the reader.
   Response: Dot points are provided to clarify what measures constituted a "child friendly" assessment on P 6/7.

2. Table 1:

- Headers: Medical alone, Learning Difficulties alone, Behavioural problems alone
  Response: done on P 13.
- I suggest: 'Did not attend' rather than 'was not brought'.
  Response: the other reviewer specifically asked for it to be changed to “was not brought”, as children are dependent, we have decided to stick with that. A clarifying comment has been added under the table to explain why we have used “was not brought”.
- add percentages: done on P 13.

3. The last paragraph of the Limitations Section (beginning with 'Nevertheless') is more appropriately placed in the discussion and conclusion section. This issue of the last of follow-up for children 'in' or 'known' to the statuary authorities who do not attend recommended health follow-up is a significant and 'improvable' component of the system that is being audited. What is the purpose of 'screening' for 'unmet health needs' if the government systems established to support these vulnerable children do not action the recommendations provide by the medical providers. This short-fall is significant (according to the author's results) and is potentially relatively remedial in the content of inter-disciplinary, inter-departmental collaboration - the essential thesis of the 'child rights', child-focused' intervention.
Response: Thank you, we agree. We have moved that last paragraph of the Limitations section and re-positioned under Discussion (P10) and Conclusion (P11).