Hampshire, Isle of Wight, Portsmouth & Southampton (HIPS)

Protocol for the management of actual or suspected bruising or other injury in infants who are not independently mobile

Version 1	Ratified	2010
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Version 3	Reviewed	February 2016
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Hampshire Safeguarding Children Partnership

ISLE OF WIGHT SAFEGUARDING CHILDREN PARTNERSHIP

PSCP Portsmouth Safeguarding Children Partnership Protecting Portsmouth's Children

SSCP SOUTHAMPTON SAFEGUARDING CHILDREN PARTNERSHIP

1 Introduction

1.1 Research shows that it is very unusual for infants who are not independently mobile to sustain bruises accidentally and bruising in this age group raises significant concerns about physical abuse (Ref 1).

1.2 Studies suggest that young babies rarely have an accidental bruise and that there should be a clear explanation for these injuries (Ref 1, Ref 2).

1.3 National and local serious case reviews have identified the need for heightened concern about any bruising or injury in a baby who is not independently mobile. It is important that any suspected bruising is fully assessed even if the parents are able to provide an explanation for it. The younger the baby the more serious shouldbe the concerns about how and why even very tiny bruises on any part of the childare caused (Ref 3).

1.4 There are a number of cases reported where an infant who is significantly abused has previously had a less significant, sentinel injury, which has been seen by professionals and the child was not protected (Ref 4).

1.5 Given the vulnerability of non-mobile infants, a specific protocol is necessary to safeguard these children.

2 Principles of the protocol

2.1 Any actual or suspected bruising or other injury in an infant who is not independently mobile should be suspected as caused by physical abuse.

2.2 Injuries to children must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage, explanation given, full clinical examination, and relevant investigations. The social history should include any relevant information from Children's Services and police checks on the adult carers.

2.3 Any explanation for actual or suspected bruising or other injury in an infant who is not independently mobile needs to be assessed by a health professional with appropriate competency, usually a consultant paediatrician.

2.4 Parents or carers should be included, as far as possible, in the assessment and decision-making process regarding their child, unless to do so would jeopardise the information gathering or pose a further risk to the child.

3 Target audience

3.1 All staff in the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) area whose work brings them into contact with children.

4 Definitions

4.1 **Not independently mobile:** The term not independently mobile applies to those infants who are not yet rolling, crawling, bottom shuffling, pulling to stand or cruising ie those infants who cannot move themselves from where they are placed. However, practitioners should be aware that the likelihood of accidental bruising increases with increasing mobility; so for example, there would be more concern about bruising seen in a baby who is only just beginning to roll, than one who is walking.

4.2 **Bruising:** A bruise is a temporary, non-blanching discolouration of skin, however faint or small, with or without other skin abrasions or marks. Colouring may vary from yellow, through green, to brown, or purple. A bruise is caused by blood that hasleaked out of capillaries or other blood vessels into soft tissues under the skin. Theage of a bruise cannot be determined by its appearance.

4.3 **Other injury:** Other injuries include all possible injuries to infants, eg cuts, scratches, abrasions, burns, scalds, fractures and dislocations. (This list is not exhaustive). Please note that these injuries will be seen on the skin and other external surfaces of the body, including the eyes and inside the mouth. (see Section 7). A fracture or dislocation may cause swelling and lack of movement of the affected limb.

4.4 **Birthmark:** A birthmark is a permanent mark on the body that is present at or soon after birth – usually within the first month. Birthmarks can be either pigmented (coloured), hypopigmented (pale) or vascular (due to increased blood vessels in or under the skin). Some may blanch, but some, like bruises, may not blanch (see Section 7).

5 Action to be taken on identifying actual or suspected bruising

5.1 If the infant appears seriously ill or injured:

a) Seek emergency treatment at an emergency department (ED).
b) Notify Children's Services of your concerns and the child's location.

5.2 In all other cases (except as stated in 5.3):

a) Record what is seen, using a body map or line drawing (Appendix A).
b) Record any explanation or comments by the parent/carer word for word.
c) Make an immediate referral to Children's Services and discuss with Children's Services whether any immediate actions should be taken to ensure the child's safety.
d) Inform parents of your professional responsibility to follow HIPS LSCPs procedures and that any action by Children's Services will be informed by a paediatrician's opinion. Give parents a copy of the 'Bruising in young babies – Information for parents and carers' leaflet and answer any questions they may have.
e) Children's Services will take responsibility for leading the multi-agency response. This will include arranging a paediatric assessment, which the child should attend within 4 hours (Appendix B). As soon as a referral for suspected physical abuse in a non-mobile infant is received by MASH, they will alert the paediatric teams. This

is so that the paediatricians know to expect a referral and can work with locality teams to ensure as many of these assessments as possible are completed within working hours. The responsibility for making a formal referral to the paediatric teams will remain with locality social work teams.

5.3 **In the specific situation where the child has been presented to an emergency department (ED) by parents/carers and the presenting complaint is the bruise or injury or the trauma that is reported to have led to the bruise or injury:**

a) The child must be examined by a senior ED practitioner (Consultant or equivalent) or Paediatric Registrar. When a Paediatric Registrar examines the child, the child should be discussed with a Paediatric Consultant (or equivalent) prior to the child being discharged.
b) If there is uncertainty about the cause of the bruise a Consultant Paediatrician (or equivalent) should also examine the child within the next 24 hours, with appropriate safeguarding of the child in the interim.
c) A full history must be taken, recording any explanation or comments by the parents/carers word for word. The infant must be fully undressed and examined for evidence of current or past trauma and any other medical conditions.
d) Investigations or treatment necessary should be arranged promptly.
e) In all situations risk factors for abuse in the family must be considered and Children's Services must always be contacted by the assessing clinician to find out if any risks for abuse are known.
f) At any time, if child maltreatment is suspected, a referral should be made to Children's Services for a multi-agency assessment (Appendix B).
g) If following the full assessment of the infant in the ED, child maltreatment continues to be considered, the child should be referred to a consultant paediatrician for further assessment.
h) If following the full assessment of the infant in the ED, there are no concerns about child maltreatment, the child can be discharged. An interagency form or information sharing form should be completed and sent to Children's Services to let them know the outcome of the assessment.
i) Information should be shared routinely with health visiting and primary care.
j) Inform parents of your professional responsibility to follow HIPS procedures and that any action by Children's Services will be informed by a paediatrician's opinion. Give parents a copy of the 'Bruising in young babies – Information for parents and carers' leaflet and answer any questions they may have.

5.4 **In the specific situation where a bruise on a baby has been reported by a parent by DIGITAL means (phone/text/email/video consultation etc):**

a) If a parent or carer contacts a professional (whether a social worker, police, or health professional) with concerns about a possible bruise on a baby, then that professional should refer to Children's Services via MASH as soon as possible.
b) If a remote consultation involves the parent sending/showing digital images of a bruise a referral to Children's Services via MASH should be made.

6 Action following referral to Children's Services

6.1 **Children's Services will arrange an urgent paediatric assessment (unless alreadydone, as in 5.3) and gather background information about the family**.

6.2 The child must attend for a paediatric assessment **within 4 hours** of Children's Services receiving the referral. This should include a detailed history from the carer, review of past medical history and family history including any previous reports of bruising, and enquiry about vulnerabilities within the family. The paediatrician should explain the findings of the assessment to the parents.

6.3 Further strategy discussion must take place **between the social worker, police and paediatrician** and the outcome explained to the parents. A paediatric opinion should be given about the possibility of child maltreatment on the balance of probabilities and this must be considered in the light of other information available from health (including the GP), social care and police records including the Police National Computer. **The opinion should be given verbally and in writing immediately following the paediatric assessment (preferably using the 'PPOF – HIPS Preliminary Paediatric Opinion Form').**

7 Other specific considerations

7.1 **Birth injury:**

Both normal birth and instrumental delivery may lead to bruising and tobleeding into the white of the eye (sub-conjunctival haemorrhage). However, staff should be alert to the possibility of physical abuse even within a hospital setting andfollow this protocol if they believe the injury was not due to the delivery. Birth injuriesshould be documented by midwives caring for the infant and the handover to healthvisitors should include any birth injuries.

7.2 **Sub-conjunctival haemorrhage (SCH):**

Please see the separate Sub-conjunctival haemorrhage guidance.

7.3 **Birthmarks:**

These may not be present at birth and appear during the early weeks months of life. Blue-grey spots (slate-grey naevus), (formerly known as Mongolian blue spots) can look like bruising. Where a practitioner believes a mark is likely to be a birthmark but requires further advice to be certain, the practitioner should seek advice from a senior colleague who should see the child the same day. If there is still uncertainty a referral should be made to Children's Services.

7.4 **Self inflicted injury:**

It is very rare for non-mobile infants to injure themselves. Suggestions that a bruise has been caused by the infant hitting themself with a toy, or hitting the bars of a cot, should not be accepted without detailed assessment by a paediatrician and social worker. Sometimes, even when children are moving around by themselves, there can be concern about how a mark or bruise occurred and in these situations a referral should always be made to Children's Services.

7.5 **Injury from other children:**

It is unusual but not unknown for siblings to injure a baby. In these circumstances, the infant must still be referred for further assessment,which must include a detailed history of the circumstances of the injury, and consideration of the parents' ability to supervise their children.

8 Rationale and evidence base

8.1 Bruising is the commonest presenting feature of physical abuse in children. Systematic review of the literature relating to bruises in children shows that:

a) Bruising is strongly related to mobility (those who don't cruise, rarely bruise) (Ref 5).
b) Bruising in infants who are not independently mobile is unusual (2.2% of babies who are not yet rolling) (Ref 6).

8.2 The National Institute for Clinical Excellence (NICE) guideline 'When to suspect child maltreatment' (Ref 7) aimed at health professionals, categorises features that should lead staff to 'consider abuse' as part of a differential diagnosis, or 'suspect abuse' such that there is a serious level of concern. In relation to bruising, health professionals are advised to 'suspect abuse' and refer to Children's Services in the following situations:

a) If a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.
b) If there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a bleeding disorder) and if the explanation for the bruising is unsuitable. Examples include:
   - Bruising in a child who is not independently mobile
   - Multiple bruises or bruises in clusters
   - Bruises of a similar shape and size
   - Bruises on any non-bony part of the body or face including the eyes, ears and buttocks
   - Bruises on the neck that look like attempted strangulation
   - Bruises on the ankles and wrists that look like ligature marks

8.3 The NICE guideline (Ref 7) also advises practitioners to 'suspect abuse' when features of injury such as bites, lacerations, abrasions, scars and thermal injuries are seen on a child who is not independently mobile and there is an unsuitable explanation.

8.4 National analysis of reports published as 'New learning from serious case reviews' (Department for Education 2012) (Ref 3) reiterates the need for 'heightened concern about any bruising in any pre mobile baby….any bruising is likely to come from external sources. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the child are caused'. Numerous serious case reviews have identified situations where children have died because practitioners did not appreciate the significance of what appeared to be minor bruising in a non-mobile infant.

9 References

1) RCPCH Child Protection Companion. Paediatric Care On-line https://pcouk.org/ (access requires a subscription or RCPCH membership)

2) RCPCH Child Protection Evidence - Systematic review on Bruising https://www.rcpch.ac.uk/resources/child-protection-evidence-bruising

3) New learning from serious case reviews: a two year report for 2009-2011 (Department for Education 2012) https://www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011

4) Sentinel Injuries in Infants Evaluated for Child Physical Abuse. Sheets LK et al Pediatrics (2013) 131: 701-707

5) Bruises in Infants and Toddlers those who don't cruise rarely bruise. Sugar NF et al. Archives of Pediatric and Adolescent Medicine (1999) 153: 399-403 https://jamanetwork.com/journals/jamapediatrics/fullarticle/346535

6) Patterns of bruising in preschool children – a longitudinal study. Kemp AM et al. Archives of Disease in Childhood (2015) 100: 426-431 https://adc.bmj.com/content/100/5/426.long

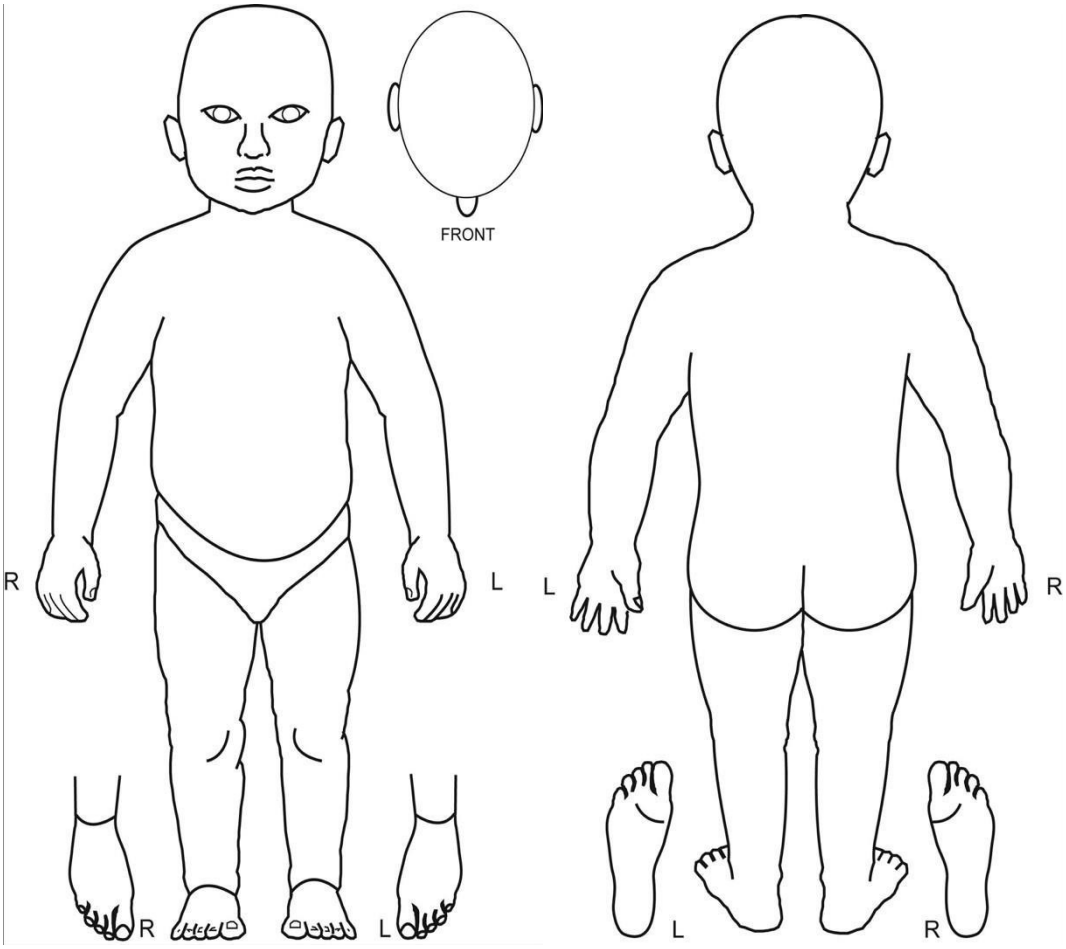
7) When to Suspect Child Maltreatment, NICE Clinical Guideline CG89 https://www.nice.org.uk/guidance/cg89

10 Additional Reading

- Working Together to Safeguard Children, HM Government, July 2018 (updated Feb 2019)
- HIPS Procedures https://hipsprocedures.org.uk
- Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, DfE May 2016
- Bruising in young babies – Information for parents and carers, NHS WHCCG Sept 2016 https://hipsprocedures.org.uk

Appendix A Skin Map

Skin map and box to record name and signature



Child's name:

Date of birth:

Date/time of skin markings/injuriesobserved:

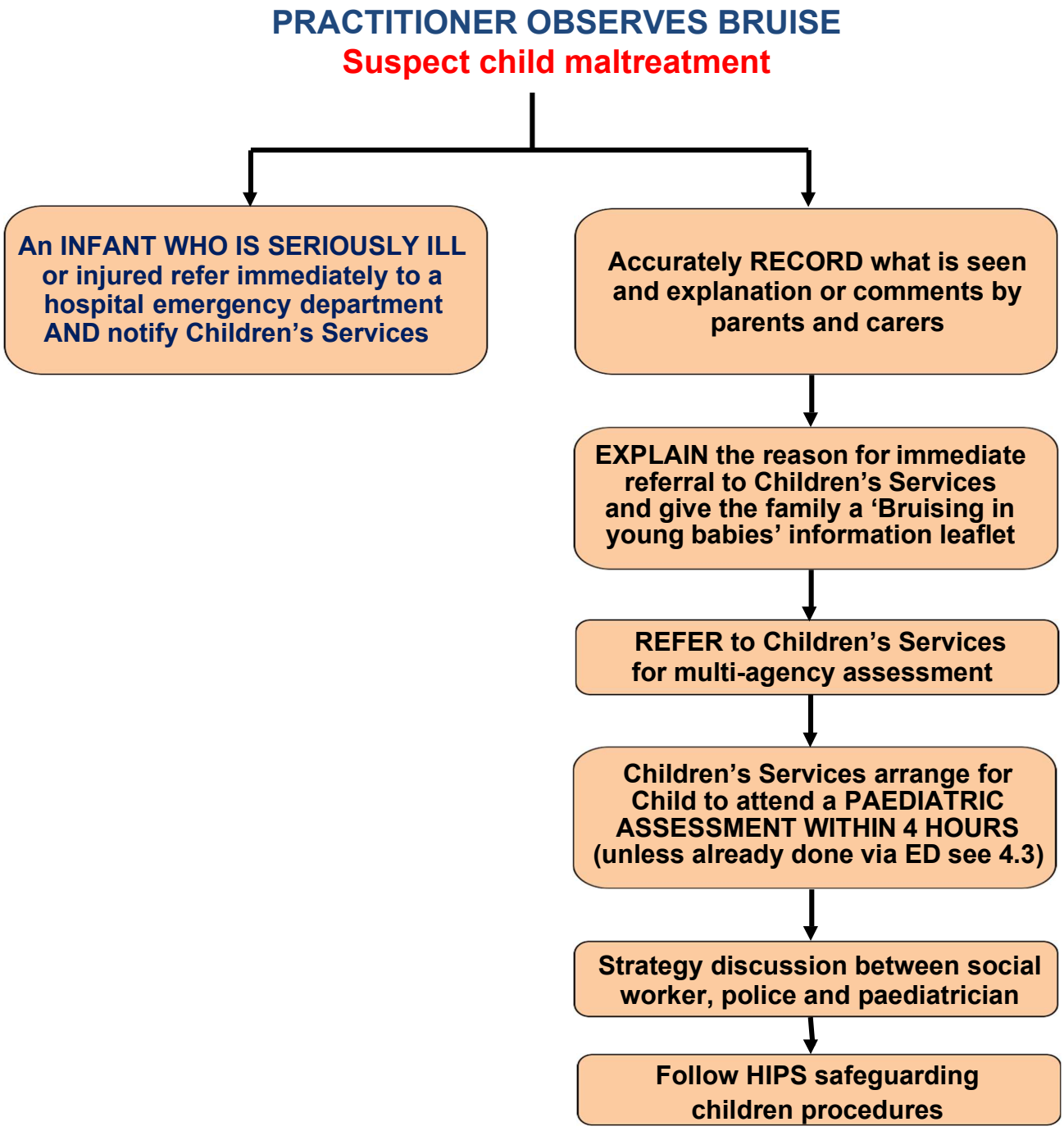
Who injuries observed by:

Information recorded: **Date:** **Time:**

Name: **Signature:**

Appendix B

Flow Chart for the Management of actual or suspected bruising in infants who are not independently mobile



CONTACT NUMBERS FOR LOCAL AUTHORITY CHILDREN'S SERVICES:

	Hampshire	Southampton	Portsmouth	Isle of Wight
Office Hours	01329 225379	023 8083 2300	023 9283 9111	0300 300 0901
Other times	0300 555 1373	023 8023 3344	0300 555 1373	0300 300 0117