

5.10 Protocol for responding to bruising and injury to non-mobile babies

Preamble

Bruising is the most common presenting feature in physical abuse in children.

- The younger the child the higher the risk that the bruising is non-accidental, especially where the child is under the age of 6 months.
- Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment
- Bruising in any pre-mobile baby should prompt an urgent senior paediatric opinion and when there is no satisfactory medical or accidental explanation for the bruising, there should be an immediate referral to Social Care.

1. Aim of the protocol

- 1.1 The aim of this protocol is to provide frontline health and other professionals with a knowledge base and action strategy for the assessment, management and referral of pre-mobile babies who present with bruising or otherwise suspicious marks. (See Section 6 below for definitions)
- 1.2 It does not reiterate the process to be followed once a referral to Children's Social Care has been made. For this, practitioners must consult LSCB procedures.

2. Target audience

- 2.1 All professionals who may come across bruising to pre-mobile babies.

3. Disabled children

- 3.1 Consideration should be given to applying this protocol to older children who are not independently mobile by reason of a disability. If in any doubt, professionals should ring Children's Social Care to discuss the case.

4. Introduction

- 4.1 Bruising is the commonest presenting feature of physical abuse in children.

The NICE guideline 'When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009) states that bruising in any child not independently mobile should prompt suspicion of maltreatment. See:

<http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English>

There is a substantial and well-founded research base on the significance of bruising in children. See:

<http://www.core-info.cf.ac.uk/bruising>

- 4.2 Bruising is rare in immobile infants, particularly those under the age of six months. Such bruising should always be taken seriously as the risks to such infants of severe and potentially fatal physical abuse are high.
- 4.3 In the light of these findings this protocol has been developed for the assessment and management of bruising in pre-mobile babies and the process by which such children should be referred to Children's Safeguarding Services and a senior paediatrician for further assessment and investigation of potential child abuse.
- 4.4 This protocol is necessarily directive. While it recognises that professional judgment and responsibility have to be exercised at all times, it errs on the side of safety by requiring that all pre-mobile babies with bruising be referred to Children's Safeguarding Services and for a senior paediatric opinion where there is no satisfactory medical or accidental explanation for the bruising.

5. Scope of the protocol

- 5.1 Any bruising, or what is believed to be bruising, in a child of any age that is observed by, or brought to the attention of any professional should be taken as a matter for inquiry and concern. This protocol relates only to bruising in pre-mobile babies, that is to say babies who are not yet crawling, shuffling, pulling to stand, cruising or walking independently.
- 5.2 It is not always easy to identify with certainty a skin mark as a bruise.

Practitioners should take action in line with this protocol if they believe that there is a possibility that the observed skin mark could be a bruise or could be the result of injury or trauma.
- 5.3 It is accepted that marks could be the result of birth trauma, birth marks or areas of skin pigmentation such as 'Mongolian Blue Spots', however if there is any doubt whatsoever as to the nature of the mark caution should be exercised and this protocol should be followed.
- 5.4 While accidental and innocent bruising is significantly more common in older mobile children, professionals are reminded that mobile children who are abused may also present with bruising. They should seek a satisfactory explanation for all such bruising, and assess its characteristics and distribution, in the context of personal, family and environmental history, to ensure that it is consistent with an innocent explanation.
- 5.5 Immobility, for example due to disability, in older children should particularly be taken into account as a risk factor. Disabled children have a higher incidence of abuse whether mobile or not.

6. Definitions

- 6.1 Pre-mobile baby: A baby who is not yet crawling, bottom shuffling, pulling to stand, cruising or walking independently. This includes all babies under the age of six months.
- 6.2 Bruising: Extravasation of blood in the soft tissues, producing 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. This includes petechiae, which are red or purple non-blanching spots, less than two millimetres in diameter and often in clusters.

7. Emergency admission to hospital

- 7.1 Any child who is found to be seriously ill or injured, or in need of urgent treatment or further investigation, should be referred immediately to hospital.
- 7.2 Occasionally spontaneous bruising may occur as a result of a medical condition such as a bleeding disorder, thrombocytopenia or meningococcal or other acute infection. A referral to hospital under the above circumstance should not be delayed by a referral to Children's Social Care, which, if necessary, should be undertaken from the hospital setting. However, it is the responsibility of the professional first dealing with the case to ensure that, where appropriate, a referral to Children's Social Care has been made.
- 7.3 It should be noted that children may be abused (including sustaining fractures, serious head injuries and intra-abdominal injuries) with no evidence of bruising or external injury.

8. Referral to Children's Safeguarding Services

- 8.1 The presence of any bruising in pre-mobile babies of any size, in any site, should initiate a detailed examination and inquiry into its explanation, origin, characteristics and history. The child should then be referred to Children's Safeguarding Services if there is no satisfactory medical or accidental explanation for the bruising.
- 8.2 Where a decision to refer is made, it is the responsibility of the first professional to learn of or observe the bruising to make the referral. The decision to refer may be undertaken jointly with another professional or senior colleague. However this discussion should not delay an individual professional of any status referring to Children's Safeguarding Services any child with bruising who, in their judgement, may be at risk of child abuse.
- 8.3 An individual practitioner must not be afraid to challenge the opinion of a colleague if they believe in their own judgement that a child might be at risk of harm, especially a very young child who will be particularly vulnerable.

- 8.4 Children's Safeguarding Services will take any referral made under this protocol as requiring further multi-agency investigation. Children's Safeguarding Services will initiate Section 47 enquiries if needed and will involve all appropriate agencies such as police as per protocol. Children's Safeguarding Services will contact the Paediatrician to whom referral is also made under section 10 below for a medical opinion before reaching any final conclusions on the case.
- 8.5 Referrals should, in the first instance, be made by telephone to **01926 410410** 9.00-17.30 (5.00 pm on Fridays) and out of hours and after 17.30 (5.00 pm on Fridays) and weekends and Bank Holidays on **01926 886922**.
- 8.6 All telephone referrals must be followed up within 24 hours with a written referral.

9. Referral for a paediatric opinion

- 9.1 If a referral is being made to Children's Safeguarding Services by a health professional, Children's Safeguarding Services should take responsibility for making a referral to the acute paediatric services through the Consultant Paediatrician on call.

Referrals from South Warwickshire should be made to the on-call paediatrician at Warwick Hospital (01926 495 321)

Referrals from North and East Warwickshire, including Rugby, should be made to George Eliot Hospital during working hours (024 7635 1351) and to UHCW out of hours (024 7696 4000)

- 9.2 In situations where the bruising is being reported by non-health professionals, Children's Safeguarding Services will make the referral for a paediatric assessment.
- 9.3 The referral should be made, and the child seen, on an urgent and immediate basis. Wherever possible, a member of staff from Children's Safeguarding Services should accompany the family at the assessment.
- 9.4 The relevant paediatrician must liaise with Children's Safeguarding Services with regard to the outcome of the assessment as soon as it is completed.
- 9.5 Where a referral is delayed for any reason, or where bruising is no longer visible, a senior paediatrician must still examine the child to assess, as a minimum, general health, signs of other injuries or pointers to maltreatment, and to exclude bleeding disorders.

10. Innocent bruising

- 10.1 It is recognised that a small percentage of bruising in pre-mobile babies will have an innocent explanation (including medical causes). Nevertheless, because of the difficulty in excluding non-accidental injury, practitioners should seek advice from a paediatrician and Children's Safeguarding Services in all such cases.
- 10.2 Any case where there is no satisfactory medical or accidental explanation for the bruising should be subject to a strategy discussion involving the referrer, children's social care, the paediatrician and the police. The strategy meeting should consider all medical findings and the full circumstances of the case before deciding on an appropriate course of investigation or management.

11. Assessment and risk

- 11.1 A bruise must never be interpreted in isolation and must always be assessed in the context of medical and social history, developmental stage and explanation given. A full clinical examination and relevant investigations must be undertaken.
- 11.2 The younger the child the greater the risk that bruising is non-accidental and the greater the potential risk to the child.
- 11.3 Bruising which might be indicative of abuse includes:
- Bruising on the head, especially the face, ears and neck, and bruising or swelling of the scalp
 - Multiple bruising, especially of uniform shape or symmetrical positions
 - Bruises in clusters
 - Large bruises
 - Bruising on soft tissues (away from bony prominences) especially cheeks and around eyes
 - Bruising on the abdomen, upper limbs (especially arms and hands), buttocks and back
 - Bruising around the anus or genitals
 - Imprints and patterns, including fingertip bruising, hands, rods, ropes, ligatures, belts and buckles
 - Bruising caused by an object or implement may not always show a typical imprint of the injuring object
 - Accompanying injuries such as scars, scratches, abrasions, burns or scalds

- Bruising in a disabled child

12. Documentation

- 12.1 The importance of signed, timed, accurate comprehensive contemporaneous records cannot be over-emphasised.
- 12.2 It is good practice to photograph any visible injuries. Ideally these photographs will be taken by the medical photography department following a request by the clinician examining the child.
- 12.3 It is good practice to make use of a body map if documenting patterns of bruising.

13. Working in partnership with parents or carers

- 13.1 Unless it is considered that this would place the child at further risk, the professional's concerns should be discussed with parents or carers of the child at the time they arise/occur, taking care that the professional does not suggest to the parents/carers how the injury has occurred.
- 13.2 The child's parents or carers should be informed of any intention to make a referral to Children's Safeguarding Services – unless it is considered that this would place the child at further risk.
- 13.3 If the child's parents/carers are not aware of the referral, this must be made clear to Children's Safeguarding Services.
- 13.4 If a parent or carer is uncooperative or refuses to take the child for further assessment, this must be reported to Children's Safeguarding Services. If possible, the child should be kept under supervision until steps can be taken to secure his or her safety. If there are concerns about the immediate safety of the child, the police should be contacted straight away.

14. Confidentiality

- 14.1 Whenever possible, the child's parent or carer should be informed before sharing confidential information. However, if this would incur delay, or if to do so would put the child or the professional at risk, then practitioners can be reassured that confidential information may be lawfully shared if it can be justified in the public interest (Information Sharing: Guidance for Practitioners and Managers HM Government 2008). 'The public interest' includes the belief that a child may be suffering, or be at risk of suffering, significant harm. (Working Together to Safeguard Children 2010)
- 14.2 The welfare of the child is paramount – (Children Act 1989)

The Child's welfare is paramount and safeguarding and promoting it is the priority. Lord Justice Elizabeth Butler-Sloss in the Court of Appeal stated that where there is a conflict of interest between the rights and interests of a child and those of a parent, the interests of the child had to prevail under Article 8 (2) of the European Convention.